

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
ALLEGANY MARYLAND						a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1D						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
CUMBERLAND 18 DAYS						CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS 314 MAC GRUDER ST.					
SACRED HEART HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First DENEEN	Middle NMI	Last BANKS	4. DATE OF DEATH			Month 1/22/67	Day 19	Year
5. SEX MALE			6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/96	9. AGE (In years last birthday) 70			10. IF UNDER 1 YEAR Months 71 yrs.	11. IF UNDER 24 HRS Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bell Hop.</i>			10b. KIND OF BUSINESS OR INDUSTRY Hotel			11. BIRTHPLACE (County & State, or foreign country) Cumberland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANDREW BANKS						14. MOTHER'S MAIDEN NAME SUSAN (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO <i>Bronchopneumonia, aspiration type</i> INTERVAL BETWEEN ONSET AND DEATH 9 days											
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Paralysis of Throat</i> 9 day											
(c) DUE TO <i>multiple Central infarcts - cerebrovascular</i> 24 day											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>General arteriosclerosis</i>											
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year			Hour a.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 27 1966</i> to <i>22 Jan 1967</i> , that (I) (we) last saw the deceased alive on <i>21 Jan 1967</i> , and that death occurred at <i>32a</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>H. Weisman</i>						22b. DATE SIGNED <i>23 Jan 67</i>					
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN						22d. ADDRESS <i>596 Remont Cumberland, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (\$SPEC)			23b. DATE THEREOF <i>1/25/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cem. Cumberland MD</i>			23d. LOCATION (city, town or county) (State) <i>Cumberland MD</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Lewis Stein Inc. Cumb. MD</i>						25a. REC'D BY REGISTRAR DATE <i>JAN 25 1967</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. ADDRESS HYNDMAN, P.O. BOX 145		g. ZIP CODE 17533	
3. NAME OF DECEASED (Type or print) FEMALE MYRTLE		4. DATE OF DEATH Month JANUARY Day 16 Year 1967	
5. SEX WHITE		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-9-1901		9. AGE (in years last birthday) 66 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) ELLERSLIE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW KELLY	
14. MOTHER'S MAIDEN NAME LAURA OSTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO 34-625 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 Coronary Heart Disease DUE TO 171		INTERVAL BETWEEN ONSET AND DEATH 171	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Pa.		20f. (City or town) Cumberland, Pa. (County) Bedford Co. (State) Pa.	
21. I certify that (I) (this hospital) attended the deceased from 1/15/67 , '19, to 1/16/67 , '19, that (I) (we) last saw the deceased alive on 1/15/67 , '19, and that death occurred at 5:10 A.M. from causes and on the date stated above.		22b. DATE SIGNED 1/16/67	
22a. SIGNATURE R. J. Williams		22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS	
22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, BURNING (Specify) Burial		23b. DATE THEREOF Jan. 18, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.	
24. FUNERAL DIRECTOR Harvey H. Zeigler		25a. ADDRESS Hyndman, Pa.	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JAN 20 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First AROB	Middle Samuel	Last Bennett
4. DATE OF DEATH	Month 1	Day 26	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/98
9. AGE (In years last birthday) 68 yrs.	10. KIND OF BUSINESS OR INDUSTRY Machinest	11. BIRTHPLACE (County & State, or foreign country) West Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Floyd Bennett	14. MOTHER'S MAIDEN NAME Maud Nelson Bennett	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 217-10-6224	17. INFORMANT patient's chart	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema			
527.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolism			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of liver c SHT Bleeding			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERRLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 1/7 , 1967 to 1/26 , 1967, that (I) (we) last saw the deceased alive on 1/26 , 1967, and that death occurred at 8:57 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. A. PASAN			
22b. DATE SIGNED 1/27/67			
22c. PHYSICIAN'S NAME (Type) J. A. PASAN MD.	22d. ADDRESS Ridgeley, W. Va.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 30 Jan 67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Lawn Memorial Gardens	23d. LOCATION (City, town or county) (State) LaVale, Maryland
24. FUNERAL DIRECTOR SILCOX FUNERAL SERVICE	ADDRESS 404 Decatur St., Cumberland, Md.	25a. REC'D BY REGISTRAR JAN 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 28 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH		First	Middle
4. DATE OF DEATH JANUARY 17 1967		Month	Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-27-76		9. AGE (In years less birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pres. of Furniture Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME <i>Isreal</i>		14. MOTHER'S MAIDEN NAME <i>Beasie (Unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senile cerebral arteriosclerosis</i> ONSET AND DEATH DUE TO 4200 (b) <i>With Hypertension</i> 1 year DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>January 17 1967</i> to <i>January 1967</i> that (I) (we) last saw the deceased alive on <i>January 17 1967</i> and that death occurred at <i>OSP</i> M, from causes and on the date stated above.			
22o. SIGNATURE <i>Isreal Schindler</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1/19/67</i>
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/19/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Cem.</i>
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 23 1967</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 3, BOX 40, CUMBERLAND, MD.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ISAAC		First ISAAC	Middle M	Last BOORE	4. DATE OF DEATH Month JAN	Day 9	Year 1967
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-17-69	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (County & State, or foreign country) BEDFORD, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BOORE		14. MOTHER'S MAIDEN NAME MARGARET BOORE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 48 6544		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Bilateral pleural effusio				INTERVAL BETWEEN ONSET AND DEATH 5 months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)	Afternoon after heart disease & failure		3 months		
		DUE TO (c)	Suspected carcinomatosis		3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hepatic cirrosis							
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) 1977, Pa.	(County) 1966	(State) 1966
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred _____, from causes and on the date stated above.		1977, Pa. 1966 2:25 P.M.					
22a. SIGNATURE DR. S. G. WEISMAN		M.D. DR. S. G. WEISMAN	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/16/67	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL BURNING BUSH CEMETERY		23d. LOCATION (City or Town) (County) (State) ROUTE 3, BEDFORD, PA.		
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. REC'D. BY REGISTRAR JAN. 16 1967		25b. REGISTRAR'S SIGNATURE John G. Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
f. STREET ADDRESS 106½ ARCH STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VERNON		4. DATE OF DEATH Month Day Year JANUARY 4 1967	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-30-20		10. AGE (in years lost birthday) 46 yrs	
11. IF UNDER 1 YEAR Months Days Hours Min.		12. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Recovery Dept.		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND - CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PERRY BRINKMAN		14. MOTHER'S MAIDEN NAME LAVERNIA MANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes War II		16. SOCIAL SECURITY NO 212-18-1955	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		DUE TO <i>Acute Coronary Thrombosis</i> <i>Myocardial Infarction</i> Dec. 18, 1966	
		DUE TO <i>Pulmonary Edema</i> Dec. 20, 1966	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1966 to Jan 4, 1967 , that (I) (we) last saw the deceased alive on Jan 4, 1967 , and that death occurred 11:15 AM , from causes and on the date stated above.		22b. DATE SIGNED 1/4/67	
22a. SIGNATURE <i>Clay. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS 236 VA. AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 6, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS	
		25b. REC'D BY REGISTRAR JAN 9 1967	
		25b. REGISTRAR'S SIGNATURE <i>John Scarpelli</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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00007

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician's directee, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS <i>Algonquin Hotel</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	ELEANOR ^{First} FEMALE	Middle H.	4. DATE OF DEATH Month JANUARY Day 15 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-14-89	9. AGE (In years last by day) 77 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0	
10a. US. AL. OCCUPATION (Give kind of work done during total working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES COOK	14. MOTHER'S MAIDEN NAME ANNIE R. SMITH	Address MEMORIAL HOSPITAL, CUMBERLAND, MD.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO —	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Older woman, coronary heart disease</i> DUE TO <i>Generalized arteriosclerosis</i> & years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> & years (c) <i>Generalized arteriosclerosis</i> & years	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. January 15 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) — (State) —
21. I certify that (I) (this hospital) attended the deceased from January 15 1967 , that (I) (we) last saw the deceased alive on January 15 1967 , and that death occurred at 3:55 P.M. January 15 1967 , M, from causes and on the date stated above.				
22a. SIGNATURE <i>Blane M. Schindler</i>	M.D. DR. BLANE M. SCHINDLER	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED 1/15/67				
22c. PHYSICIAN'S NAME (Type) DR. BLANE M. SCHINDLER	22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 1/18/67	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Crem.	23d. LOCATION (City or Town) Cumberland	(County) MD (State) MD
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. MD.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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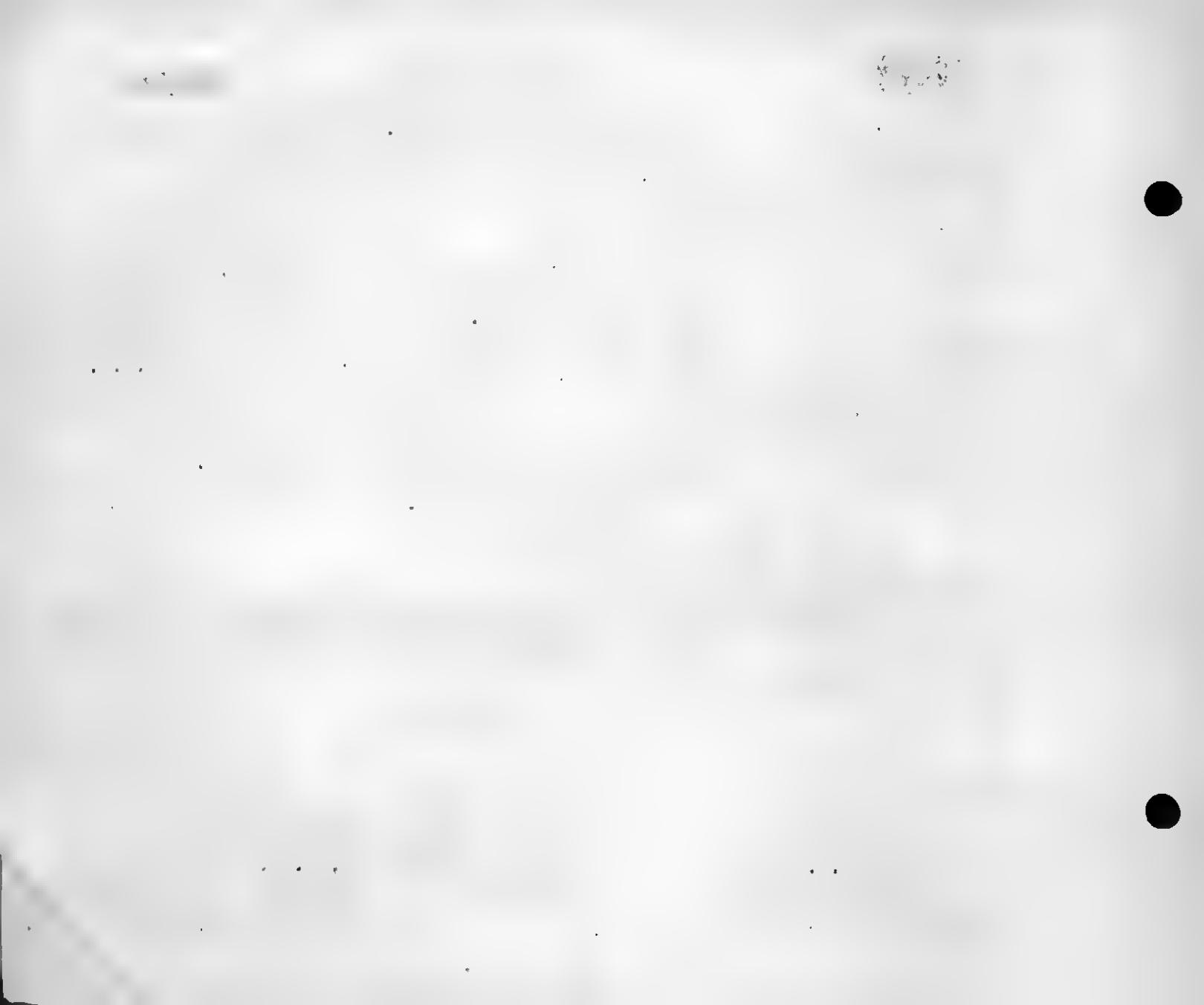
CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Allegany		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN b 63 Yrs	
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Westernport		d. STREET ADDRESS 512 Johnson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 512 Johnson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph		First Ralph	Middle Thomas
		Last Chaney	4. DATE OF DEATH Jan. 18 1967
S. SEX Male	5. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Dec. 23, 1903		9. AGE (in years last birthday) 63 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (County & State, or foreign country) Allegany-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hudson L. Chaney		14. MOTHER'S MAIDEN NAME Minnie Stienla	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Address	
		17. INFORMANT Anna Chaney-Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 318.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO		Anorexia (Starvation) 4½ Months	
(b) DUE TO		Psychoneurosis 4½ Months	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage with Complete Hemiplegia left for 15 Years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 19 1966 , to Jan 18, 1967 , that (I) (we) last saw the deceased alive on Jan. 2 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.		22b. DATE SIGNED Jan. 20, 1967	
22a. SIGNATURE Paul R. Wilson		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Piedmont, W. Va.
22c. PHYSICIAN'S NAME (Type) P.R. Wilson		23d. LOCATION (City or Town) (County) (State) Westernport Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/67	23c. NAME OF CEMETERY OR CREMATORIAL Philos
24. FUNERAL DIRECTOR J. J. Wilson		ADDRESS Westernport, Md.	25a. REC'D. BY REGISTRAR JAN 23 1967
			25b. REGISTRAR'S SIGNATURE James J. Wilson



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00009

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00009

1 PLACE OF DEATH a. COUNTY ALLEGAYE		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS BOX 136		
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) Marshall	First A.	Middle Clarke	4 DATE OF DEATH Month JANUARY	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 3-7-19	
9. AGE (in years last birthday) 47	10. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Work	11. BIRTHPLACE (State or foreign country) MIDLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT (D) Clarke	14. MOTHER'S MAIDEN NAME BERTIE (CUTTER)	Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> Yes	16. SOCIAL SECURITY NO 2	17. INFORMANT PT'S CHART	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural Hemorrhage, Right DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Rupture of congenital aneurysm of right posterior cerebral artery DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
INTERVAL BETWEEN INCUBATION AND DEATH Hours				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Cumberland (County) Md. (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				22. DATE SIGNED January 22, 1967
23b. DATE THEREOF 1/25/1967				23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
23d. LOCATION (City or Town) Cumberland, Md. (County) Md. (State)				23e. REC'D BY REGISTRAR Charles Judge
24. FUNERAL DIRECTOR GEORGE EICHORN ADDRESS Lonaconing, MD.				25b. REC'D BY SIGNATURE Charles Judge

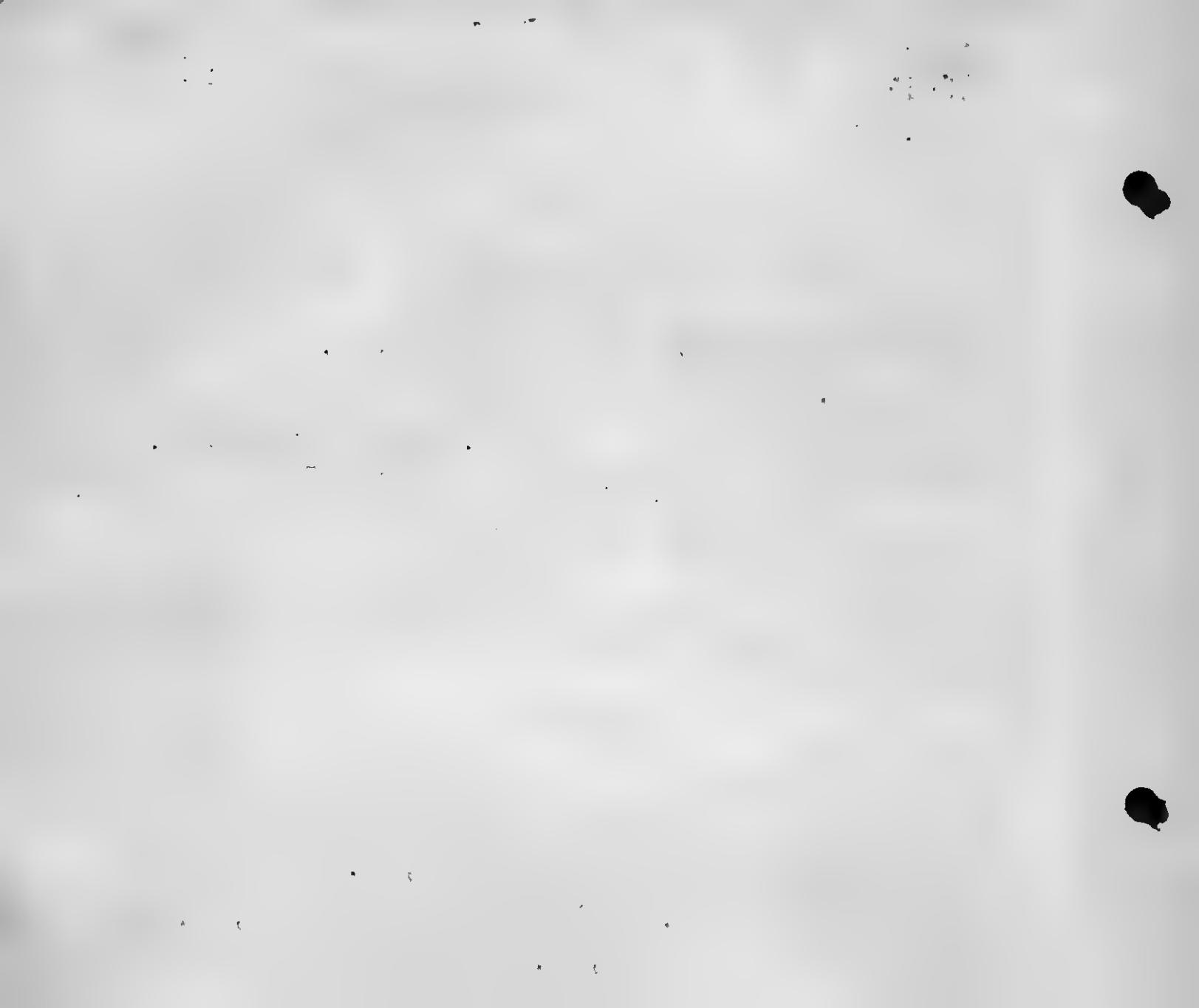


STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is required, writing the word "pending" in pencil in Item 18, ^{Give} pages 1, 2, and 3 to the funeral director, and ^{Item} page 3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00010		00010	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY Allegany		STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		b. COUNTY Allegany	
c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		4. DATE OF DEATH	Month 1/16/1967 19
		5. SEX	6. COLOR OR RACE
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
		3/29/1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Celanese Corp)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Midland, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John S. Coleman		14. MOTHER'S MAIDEN NAME Ellen Tighe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank and date of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT	
		John R. Jones Midland, MD. (Step-Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1/20/1</i>		Coronary Occlusion	
Conditions, if any, which gave rise to immediate cause (a), being the underlying cause lost. } (b)		Coronary Sclerosis	
DUE TO <i>1/20/1</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		DATE SIGNED 1/16/1967	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/1967	
22c. NAME OF CEMETERY OR CREMATORIUM St. Josephs Cemetery		22d. LOCATION (City, town, or county) Midland, MD. (State)	
23. FUNERAL DIRECTOR GEORGE EICHORN		24a. REC'D BY REGISTRAR VS. ATISME 5M 9 60	
		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		ADDRESS Lonaconing, MD.	
		DATE JAN 23 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00011

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10a Page 4 may be retained by the hospital or attending physician.
10b FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 79 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETTA		Middle F.	Last CONWAY
4 DATE OF DEATH JANUARY 8 1967		Month	Year
S SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 88 yrs
13. FATHER'S NAME CHRISTOPHER BOOGHER		11. BIRTHPLACE (County & State, or foreign country) FREDERICK, MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive arterio sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 443X (b) <i>Cardio vascular disease</i> (c) <i>7-23-63</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-23-63, 198:05 P.M. - 1-8-1967 that (I) (we) last saw the deceased alive on 1-8-1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE <i>W. F. Williams M.D.</i>		22b. DATE SIGNED 1-9-67	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/67	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.
24. FUNERAL DIRECTOR <i>Lane Stein Inc</i>		ADDRESS Cumb. Md.	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

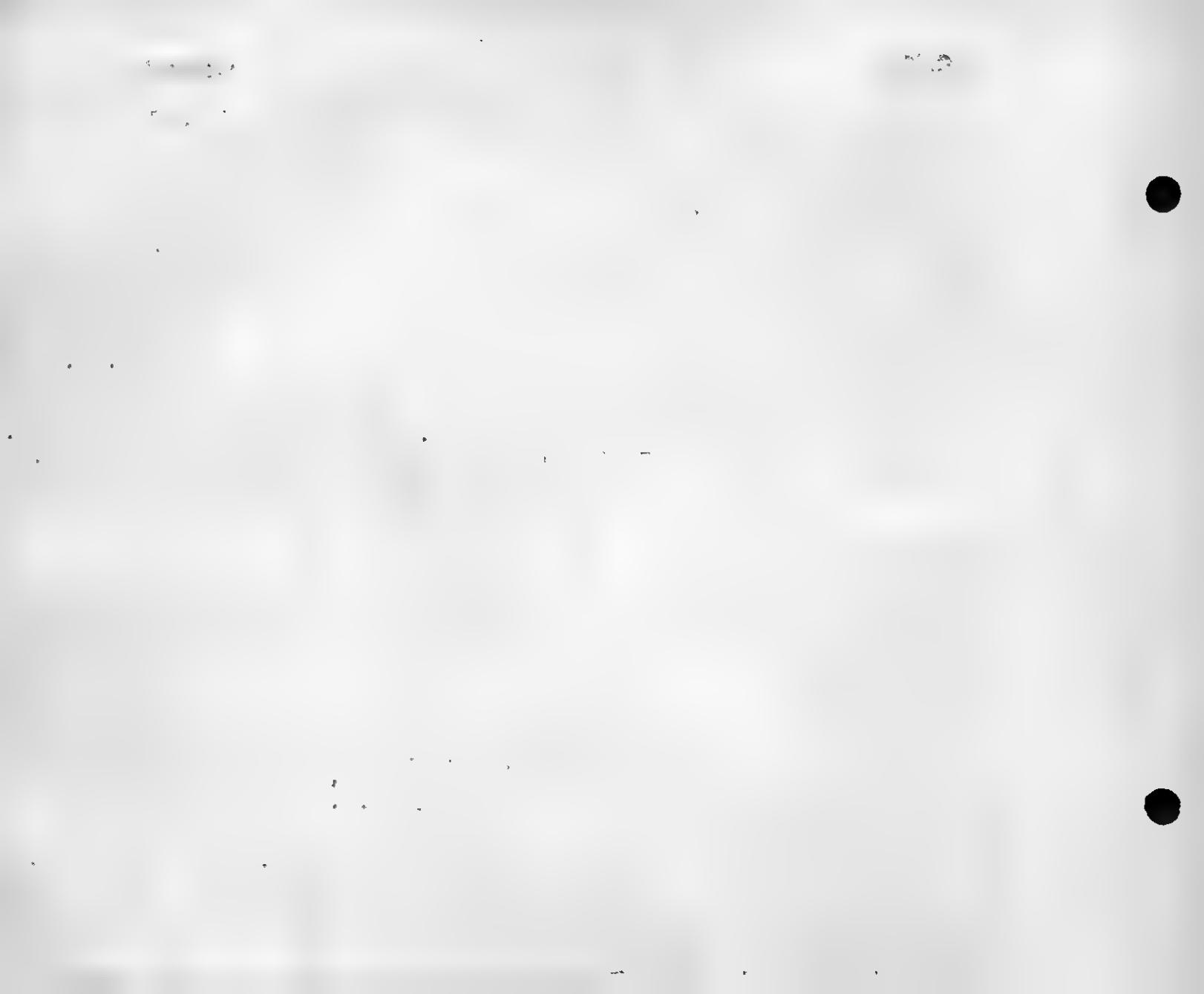
00012

CERTIFICATE OF DEATH

00012

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 7/7/1966	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED First Bessie Middle Louise DAVIS		d. STREET ADDRESS 217 Carroll Street	
SEX Female COLOR OR RACE White Black MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		4. DATE OF DEATH January 21, 1967	
5. 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		5. B. DATE OF BIRTH 8/9/1874	
6. 10b. KIND OF BUSINESS OR INDUSTRY		6. AGE (in years lost birthday) 92 yrs	
7. 11. BIRTHPLACE (County & State, or foreign country) Maryland		7. IF UNDER 1 YEAR Months Days Hours Min.	
8. 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
9. 13. FATHER'S NAME Baker Daniel Banks		14. MOTHER'S MAIDEN NAME Elizabeth Robinson	
10. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 219-54-1207	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address: Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hyperthyroidism, abn. degeneration. Seizure</i> DUE TO <i>Arterio Sclerosis, general-</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <i>Hypotension</i> DUE TO (c) <i>Refractory Bleeding - probably malignant</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/7/1966, 19, to 1/21, 1967, that (I) (we) last saw the deceased alive on 1/21, 1967, and that death occurred at P. M. from causes and on the date stated above		at 4:20 P.M.	
22a. SIGNATURE <i>Charles L. Mathews</i>		22b. DATE SIGNED 1/23/1967	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 24, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg., Md.	
24. FUNERAL DIRECTOR John J. Hafer		25a. REC'D BY REGISTRAR	
John J. Hafer, Jr., 230 Balto Ave. Cumberland		25b. REGISTRAR'S SIGNATURE JAN 24 1967 <i>Charles L. Mathews</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00013

CERTIFICATE OF DEATH

00013

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lenoconing		c. LENGTH OF STAY IN b 3 Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kyle Nursing Home		d. STREET ADDRESS Cresaptown		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) Mary		First Deffinbaugh	Middle Deffinbaugh	
4 DATE OF DEATH January 12 1967	Month January	Day 12	Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	
8 DATE OF BIRTH June 13, 1892	9 AGE (In years lost birthday) 74 yrs.	10. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State or foreign country) New York City	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME George Stierstorfer	14. MOTHER'S MAIDEN NAME Mary Hoffman	Address Cresaptown, Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No	16. SOCIAL SECURITY NO None	17. INFORMANT Boyd D. Deffinbaugh	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause 331X (b) DUE TO Conditions, if any, which gave rise to underlying cause (b). stating the underlying cause Generalized (c) DUE TO Conditions, if any, which gave rise to underlying cause (c). years	INTERVAL BETWEEN ONSET AND DEATH 1967
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 10 1967 , to Jan 12 1967 , that (I) (we) last saw the deceased alive on Jan 10 1967 , and that death occurred at M , from causes and on the date stated above				
22a. SIGNATURE L. R. MILES JR		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-13-67	
22c. PHYSICIAN'S NAME (Type) L. R. MILES JR		22d. ADDRESS LONACONING MD		
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial		23e. DATE THEREOF 1/15/67	23f. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23g. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502			25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

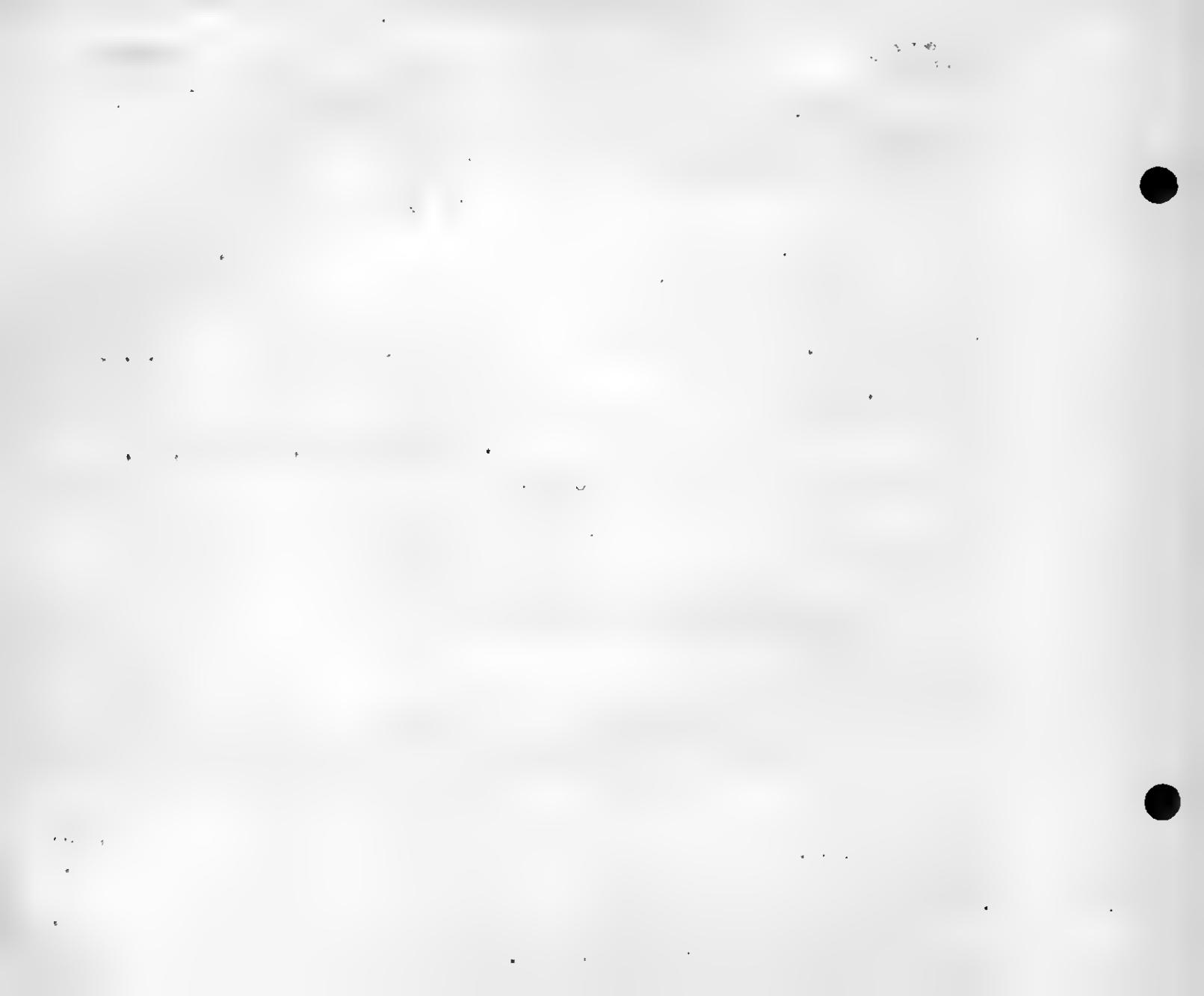
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00014

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with Form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 00014		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00014											
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1D 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abington									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 245 Barter Drive										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry		First	Middle	S	Dennison	4. DATE OF DEATH Jan. 13 1967	Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1899		9. AGE (In years last birthday) 67 yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY U.S.A.	13. FATHER'S NAME Joseph H. Dennison	14. MOTHER'S MAIDEN NAME Maude Winner		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circulation Mgr.		10b. KIND OF BUSINESS OR INDUSTRY News Paper		11. BIRTHPLACE (State or foreign country) West Virginia									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Coronary Sclerosis						DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/13/67			
Address (Street, city, town, or county) Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/67		23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City, town or county) Westernport		(State) Md.					
24. FUNERAL DIRECTOR <i>J. Boal</i>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00015

CERTIFICATE OF DEATH

00015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland			b. COUNTY Allegany		
c. LENGTH OF STAY IN b. Cumberland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 406 Virginia Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Hazel A. Dentinger		First	Middle	Last	4. DATE OF DEATH Month 1 Day 11 Year 1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/11
9. AGE (In years Months Years 55)		10. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State or foreign country) Allegany Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Dentinger			14. MOTHER'S MAIDEN NAME Hazel Green		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT patient's chart	
Address					
n. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Carcinoma from rectum					
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 live and generalized (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19, to 1-11 , 19 67 , that (I) (we) last saw the deceased alive on 1-11 19 67 , and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE Carlton Brinsford		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD MD		22d. ADDRESS 401 Decatur St. Cumberland Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland, Allegany	(County) Md. (State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS	25a. RECD BY REGISTRAR JAN 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
Bp			DATE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

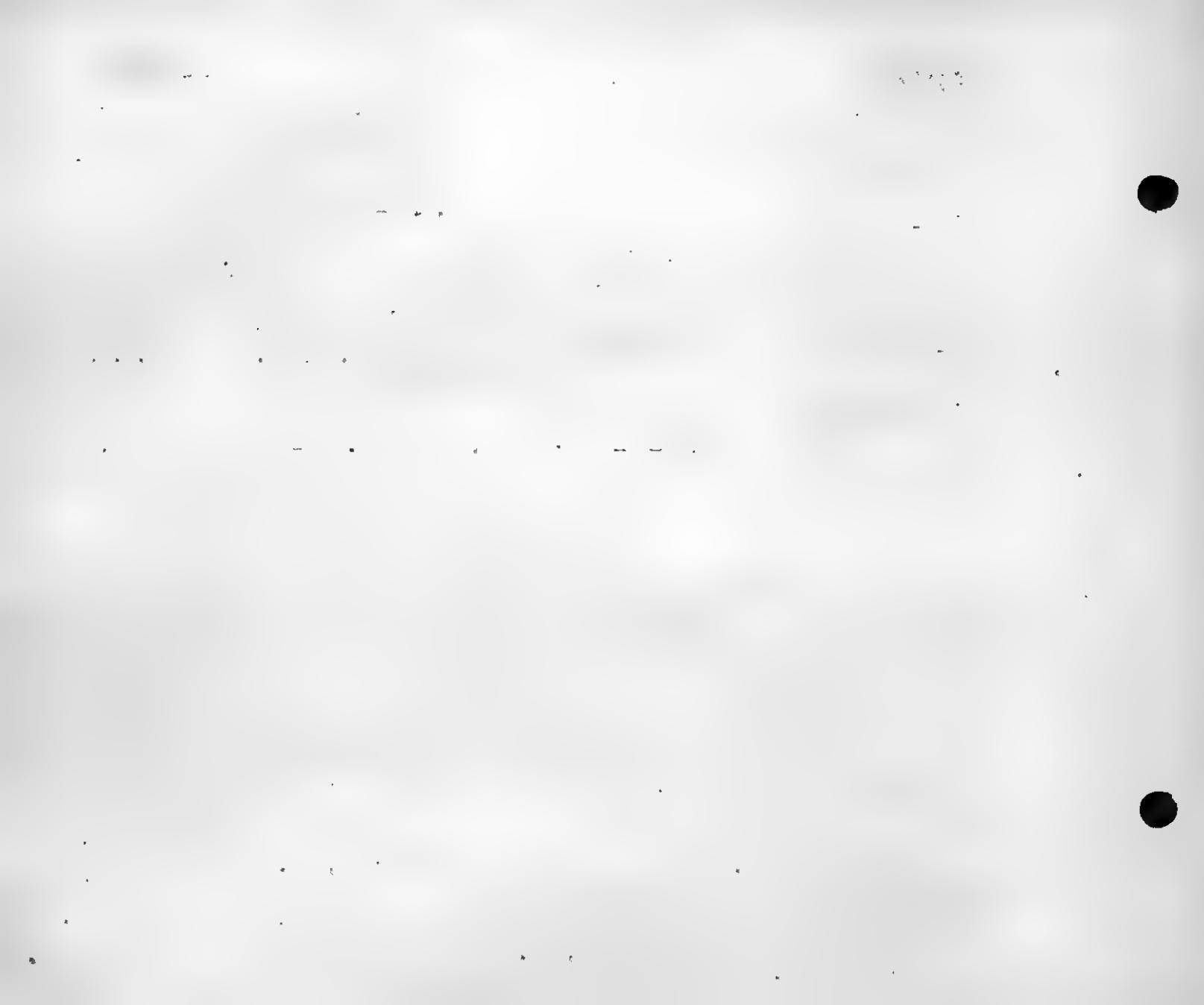
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00016

CERTIFICATE OF DEATH

00016

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1B 31 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. 1-Westernport			
3. NAME OF DECEASED (Type or print) Harry Herbert DeShong		4. DATE OF DEATH Jan. 10 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1894
9. AGE (in years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Operator	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (County & State, or foreign country) Somerset Co. Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harvey DeShong	14. MOTHER'S MAIDEN NAME Martha Allender	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no	
16. SOCIAL SECURITY NO. 214-12-3335A		17. INFORMANT Mrs. Ethel DeShong-Westernport, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Myocardial infarct Arterio sclerotic heart disease			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH months	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westernport, Md.
20f. (City or town) Westernport (County) Md. (State) Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19, to Jan , 19 67 , that (I) (we) last saw the deceased alive on Jan , 19 67 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED 1/26/67	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Westernport, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/67	23c. NAME OF CEMETERY OR CREMATORIAL Philos
24. FUNERAL DIRECTOR Charles Judge		ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR JAN 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge
VR AIS (4) 20M 1/65		DATE JAN 13 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

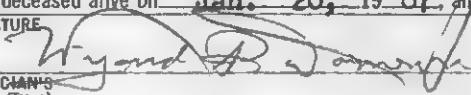
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

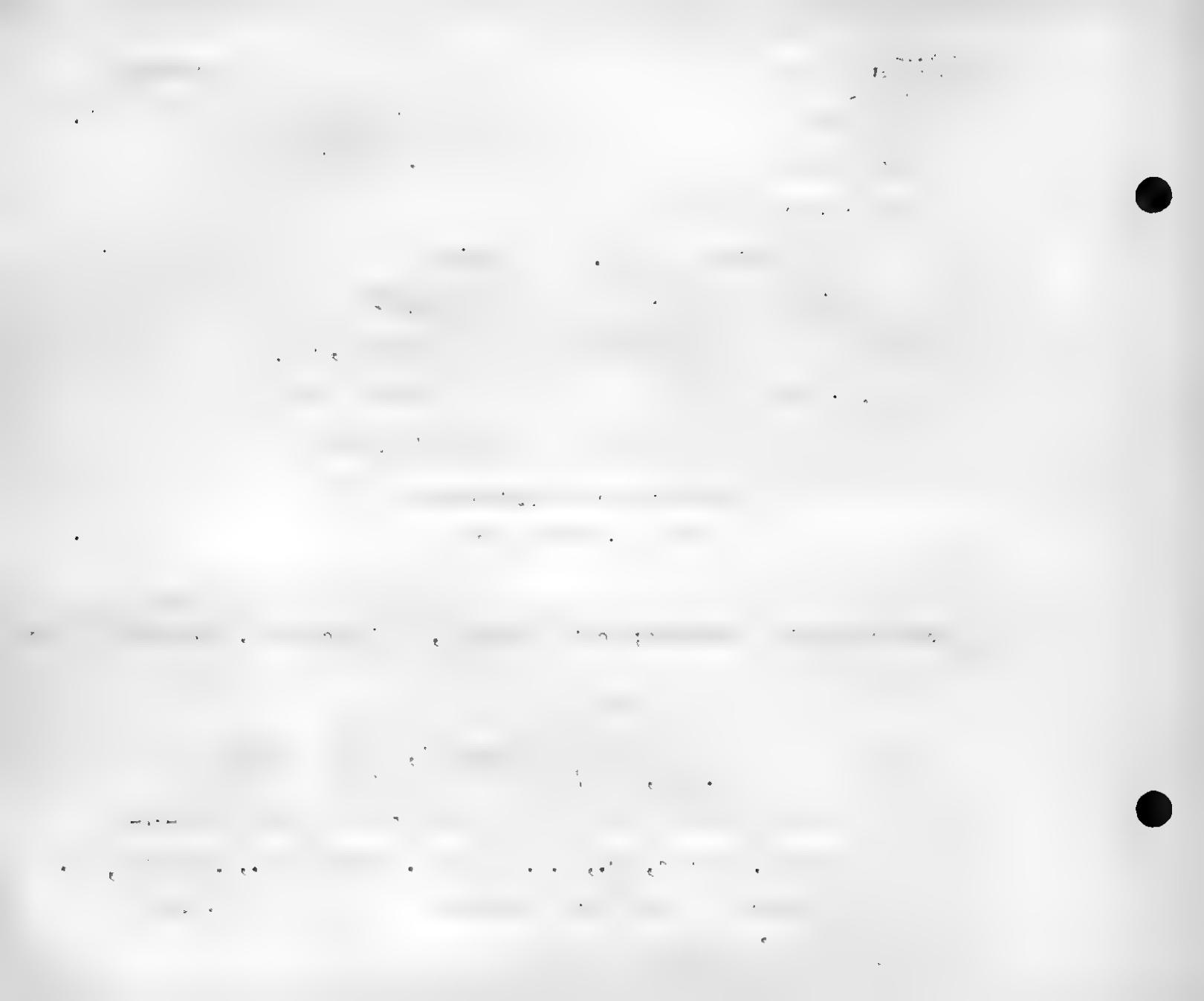
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00017

CERTIFICATE OF DEATH

00017

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle A.	Last DeVore
4. DATE OF DEATH 1 20 1967	Month 1	Day 20	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/89
9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY Railroading	11. BIRTHPLACE (County & State, or foreign country) Ellerslie, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John D. DeVore	14. MOTHER'S MAIDEN NAME Barbara Witt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 716-10-4175	17. INFORMANT patient's chart	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction			
DUE TO (b) Coronary arteriosclerosis			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute bronchitis; Emphysema; Acute occlusion, rt iliac and L.popliteal			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyndman, Pa.
20f. (City or town) Hyndman, Pa.		(County) PA.	(State) Pa.
21. I certify that (I) (this hospital) attended the deceased from January 9, 1967 , to January 20 1967 , that (I) (we) last saw the deceased alive on Jan. 20, 1967 , and that death occurred at 3:10PM , from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 1-21-67	
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		22d. ADDRESS 414 N. Mechanic St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF January 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION (City, town or county) Hyndman, PA. RD#1	
24. FUNERAL DIRECTOR 		ADDRESS Hyndman, Pa.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE JAN 25 1967	
DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00018

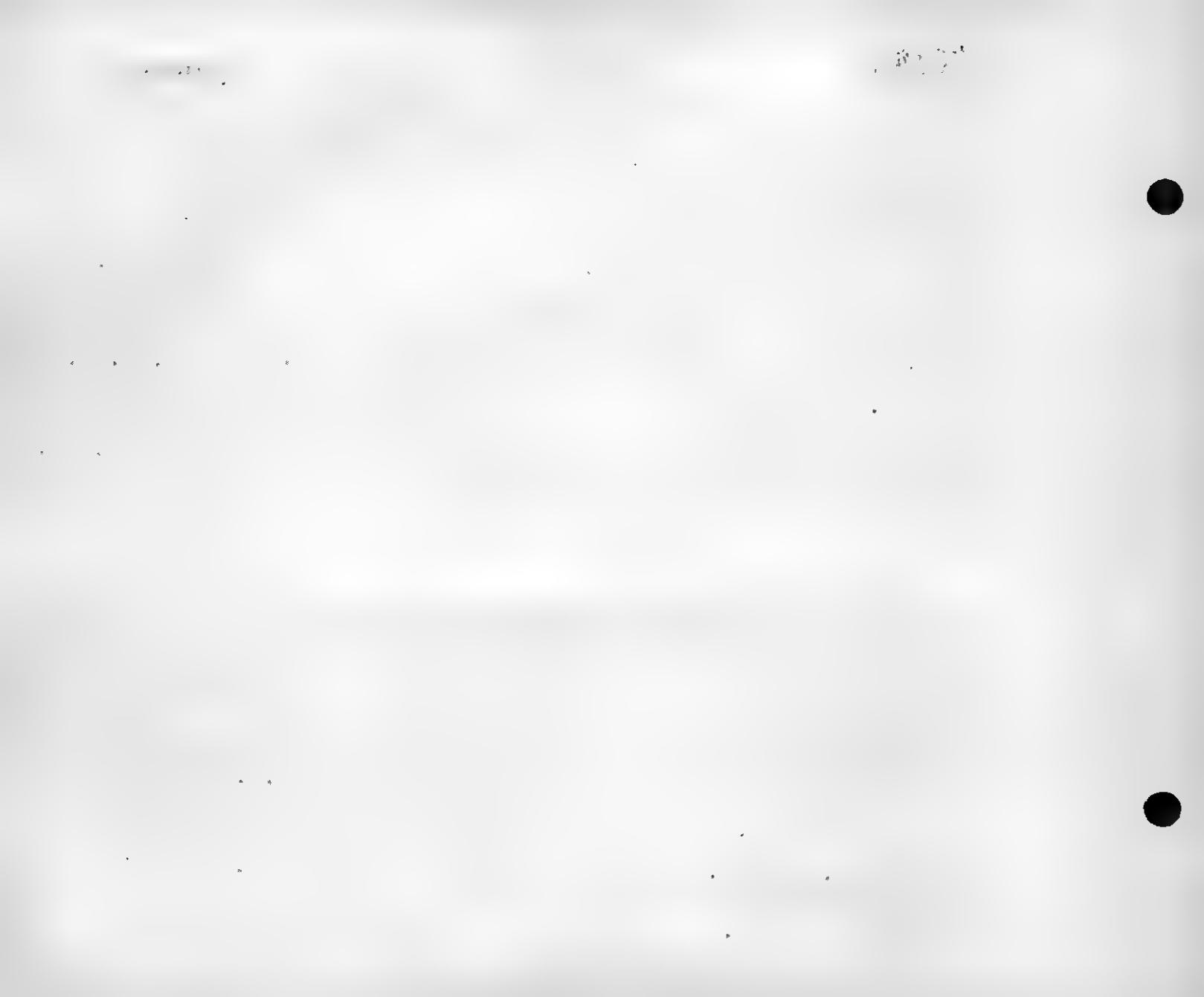
CERTIFICATE OF DEATH

00018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death!

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 29 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 704 LOUISIANA AVE.,	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last DIGGS		4. DATE OF DEATH Month JAN. Day 20, Year 1967	
S SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY W.M. RAILROAD	
13. FATHER'S NAME JOHN H. DIGGS		14. MOTHER'S MAIDEN NAME CATHERINE HAMMERSMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Death	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)		DUE TO Central Arteriosclerosis 2 yrs Myocarditis 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 1967, to Jan 20, 1967, that (I) (we) last saw the deceased alive on Jan 20, 1967, and that death occurred at 9:20 A.M. from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE CLAY E. DURRETT		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/21/67
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ST. PETER & PAUL CEM.		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	
		25a. REC'D BY REGISTRAR JAN 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00019

CERTIFICATE OF DEATH

00019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE WEST VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 11 HRS.		
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF Twin I DECEASED (Type or print) BOY		4. DATE OF DEATH JANUARY 16 19 67	Month Day Year	
S SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 15, 1967	
10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs CUMBERLAND, MD.	
13. FATHER'S NAME BILLY B. DOMAN		14. MOTHER'S MAIDEN NAME VELMA C. WEBSTER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO <i>Crematory</i> (b) _____ DUE TO _____ (c) _____				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/04 - 1-15-67 , 19 to 2/19 , 19, that (I) (we) last saw the deceased alive on 19 , and that death occurred at :06 PM , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE <i>Charles H. Nadeau</i>		22b. DATE SIGNED JAN 19 1967		
22c. PHYSICIAN'S NAME (Type) DR. O. H. NADEAU		22d. ADDRESS 600 VIRGINIA AVE, CUMBERLAND, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-18-67		23b. DATE THEREOF 1-19-67	23c. NAME OF CEMETERY OR CREMATORIAL Ashbury	23d. LOCATION (City or Town) (County) (State) Bear Settlement Cemetery
24. FUNERAL DIRECTOR <i>R. L. Legg & Son Funeral Directors</i>		ADDRESS 101 W. Main Street, Cumberland	25a. REC'D BY REGISTRAR DATE JAN 19 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00020

CERTIFICATE OF DEATH

00020

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 8 HRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY,	d. STREET ADDRESS BOX 68
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GIRL	First Twin II Middle	Last DOMAN	4. DATE OF DEATH Month JANUARY Day 15 Year 1967
S SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. Months Days Hours Min
			1 - 8 34
13. FATHER'S NAME BILLY B. DOMAN		14. MOTHER'S MAIDEN NAME VELMA C. WEBSTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 77% X IMMEDIATE CAUSE (a) DUE TO <i>Penitentiary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Part 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital)-attended the deceased from 20:40-1-15, 1967, to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 10:40 P.M. from causes and on the date stated above			
22c. PHYSICIAN'S NAME (Type) DR. O. H. NADEAU		M.D. ATTENDING PHYS. <input type="checkbox"/> ADDRESS 22d. ADDRESS 600 VIRGINIA AVE., CUMBERLAND, MD.	22b. DATE SIGNED 25a. REC'D BY REGISTRAR DATE JAN 19 1967 25b. REGISTRAR'S SIGNATURE Judge
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF B.J. 1-15-67	23c. NAME OF CEMETERY OR CREMATORIAL Ashbury	23d. LOCATION (City or Town) (County) (State) Bear Bottom Road Hardy Co.
24. FUNERAL DIRECTOR B.L. Updegraff	ADDRESS 100 N. Main Street	25a. REC'D BY REGISTRAR DATE JAN 19 1967	25b. REGISTRAR'S SIGNATURE Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

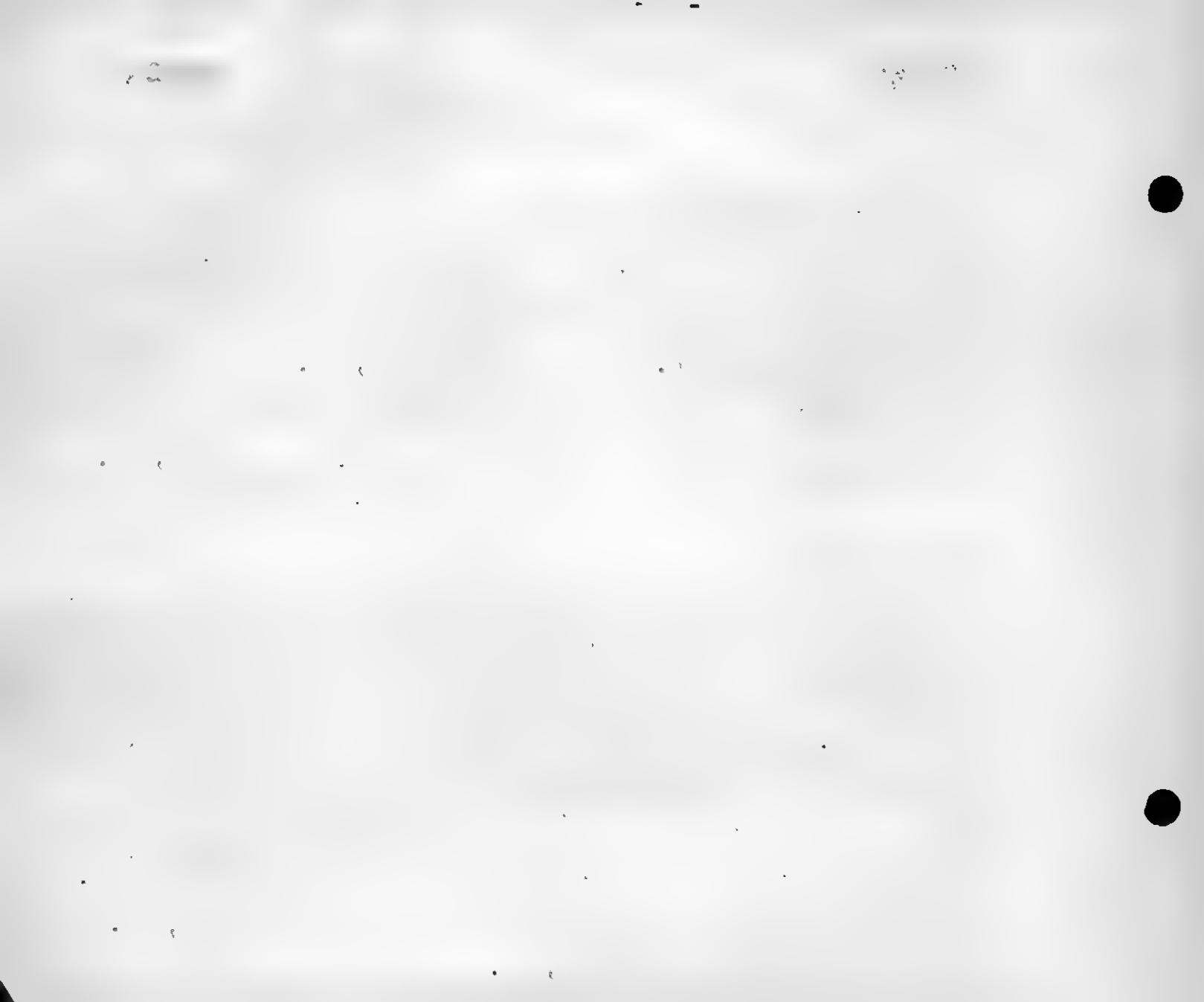
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00021

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00021

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. COUNTY Maryland Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Midland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES		First J	Middle EAGAN	4. DATE OF DEATH 1/28/1967	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1883	9. AGE (In years lost birthday) 83 yrs	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Kelly Tire Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Midland, MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Eagan			14. MOTHER'S MAIDEN NAME Anna Mc Alister		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT Garrett Eagan	Address Midland, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage; Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Contusions of Brain DUE TO (c) (Fall at Home)			(SON)		INTERVAL BETWEEN ONSET AND DEATH 4 Hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Coronary Sclerosis, Marked; Arteriosclerosis generalized					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell at home			
20c. TIME OF DEATH Month, Day, Year Hour AM/PM 3:00 pm Jan. 28 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	20f. (City or town) Midland, Allegany, Maryland	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE BENEDICT SKITARELIC	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED January 28, 1967
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/31/1967	23c. NAME OF CEMETERY OR CREMATORIUM St Michaels Cemetery	23d. LOCATION (City or Town) Frostburg	(County)	(State) MD.
24. FUNERAL DIRECTOR GEORGE EICHORN	ADDRESS Lonaconing, MD.	25a. REC'D BY REGISTRAR	25b. REC'D BY SIGNATURE Frances Judge		
VR A15ME (5) 6M 1/66		DATE JAN 31 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 5,17 Film G385 2/14/67 mh

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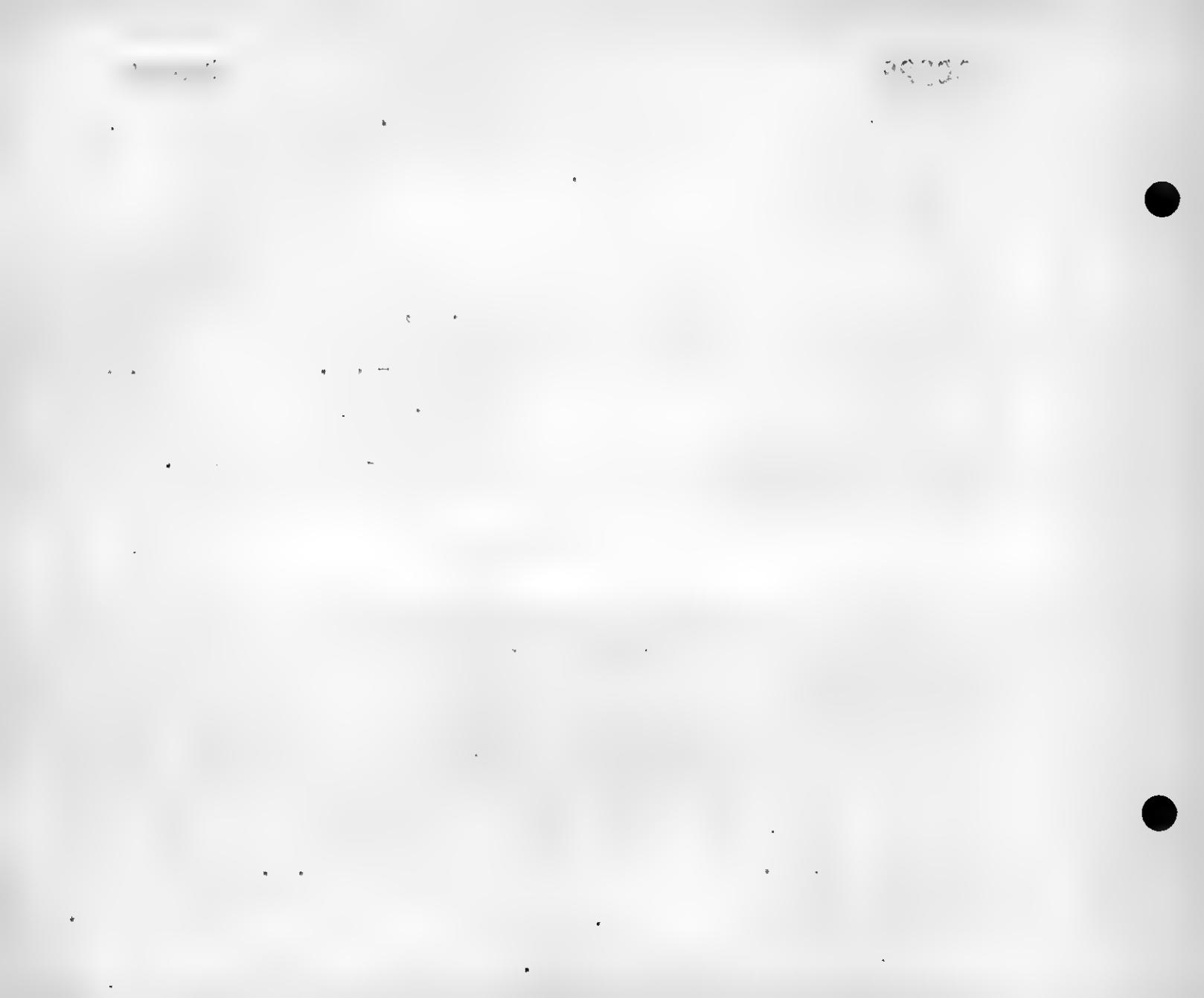
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00022

CERTIFICATE OF DEATH

00022

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 64 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 468 Spruce			d. STREET ADDRESS 468 Spruce		
3. NAME OF DECEASED (Type or print) Laura	First Ellen	Middle Elias	Last Elias	4. DATE OF DEATH Jan 31 1967	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1885	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mineral-W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Seymour Welsh			14. MOTHER'S MAIDEN NAME Tacey Walters		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes g've war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Elias Address George Elias-Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocardiitis</u> DUE TO <u>Arterio-Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <u>10 Years</u>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Hemorrhage and Carcinoma of Breast in 1964</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1962</u> , to <u>Jan 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 30, 1967</u> , and that death occurred at <u>1245</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Paul R. Wilson</u>					
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/67	23c. NAME OF CEMETERY OR CREMATORIAL St. Peters		23d. LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR		ADDRESS Westernport, Md.		25a. RECD BY REGISTRAR DATE 5/10/67	25b. REGISTRAR'S SIGNATURE <u>Stanley Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00023

CERTIFICATE OF DEATH

00023

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/3/1964		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 761 Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED First Frank Middle a. Last Fogtman				4. DATE OF DEATH January 15, 1967				
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 10/8/1881	9. AGE (In years 85 last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Paperhanger			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Fogtman				14. MOTHER'S MAIDEN NAME Anna Fox				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <i>Deafness, bilateral degenerative disease</i> <i>of external auditory canal, general (3) At least one ear</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Sensory nerve (4) Bilateral</i> <i>colorectal (5) Such total deafness,</i> (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/3/64, 19, to 1/15/67, 19, that (I) (we) last saw the deceased alive on 1/14/67, 19, and that death occurred at A. M. from causes and on the date stated above.								
22a. SIGNATURE <i>Lee B. Mathews M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 1/16/1967			
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/19/67	23c. NAME OF CEMETERY OR CREMATORIAL Helenswood Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Md			
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		
				DATE JAN 23 1967				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA		b. COUNTY MINERAL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENSPRING, W. VA.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FANNY	Middle M	Last FOLEY	4. DATE OF DEATH JAN 23 1967	Month JAN	Day 23	Year 1967
S. SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-27-86	9 AGE (in years last birthday) 80 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT NELSON		14. MOTHER'S MAIDEN NAME ETTA HAINES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema - Acute Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Arteriosclerotic Cardiovascular Disease</i>							
DUE TO (b) <i>Old Age</i>							
DUE TO (c) <i>Old Age</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 , to 1967 , that (I) (we) last saw the deceased alive on Jan 23 1967 , and that death occurred 2:50P M, from causes and on the date stated above.							
22a. SIGNATURE <i>DR. G. OVERTON HIMMELWRIGHT</i>		22b. DATE SIGNED 1/25/67					
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VA. AVENUE, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-26-67		23c. NAME OF CEMETERY OR CREMATORIAL Forest Glen		23d. LOCATION (City or Town) (County) (State) Green Spring Hamp. W. Va.	
24. FUNERAL DIRECTOR <i>Jack Skaffner Romney Wm.</i>		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE FEB 1 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 25 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELINOR P. GEARE		4. DATE OF DEATH JANUARY 15 1967	Month Doy Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT PAUL		14. MOTHER'S MAIDEN NAME ROSALIE DEVEMON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO —	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <i>Acute myocardial infarction, non-syphilitic</i> DUE TO <i>4/20/1</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Hypertension w/ Atherosclerotic disease</i> DUE TO <i>5 years.</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		25	
21. I certify that (I) (this hospital) attended the deceased from 9:50 a.m. to 10:30 a.m. on Jan. 19, 1967, that (I) (we) last saw the deceased alive on 19, and that death occurred at 1:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>W. Alfred Van Ormer</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 15 Jan. 67
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF 1/18/67	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>
24. FUNERAL DIRECTOR <i>Lewis Stein Inc. Cumb. Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE JAN 23 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut) Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rural" Frostburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence		First T.	Middle Green	4. DATE OF DEATH January 12 1967	Month January	Doy 12	Year 1967		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/2/1917	9. AGE (In years from birthday) 50 yrs	11. UNDER 1 YEAR Months 0	12. UNDER 24 HRS Days 0		
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Ternent		14. MOTHER'S MAIDEN NAME Rachael Darnley		Address Frostburg, Md.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Lindley E. Green		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO C.V.H.P.D. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) Coronary occlusion		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg, Md.	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE John B. Gravie		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Frostburg, Md.		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/14/1967		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) Cumberland		(County) A.	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR JAN 16 1967		25b. REC STRR'S SIGNATURE Charles Judge		(State) Md.	



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00027

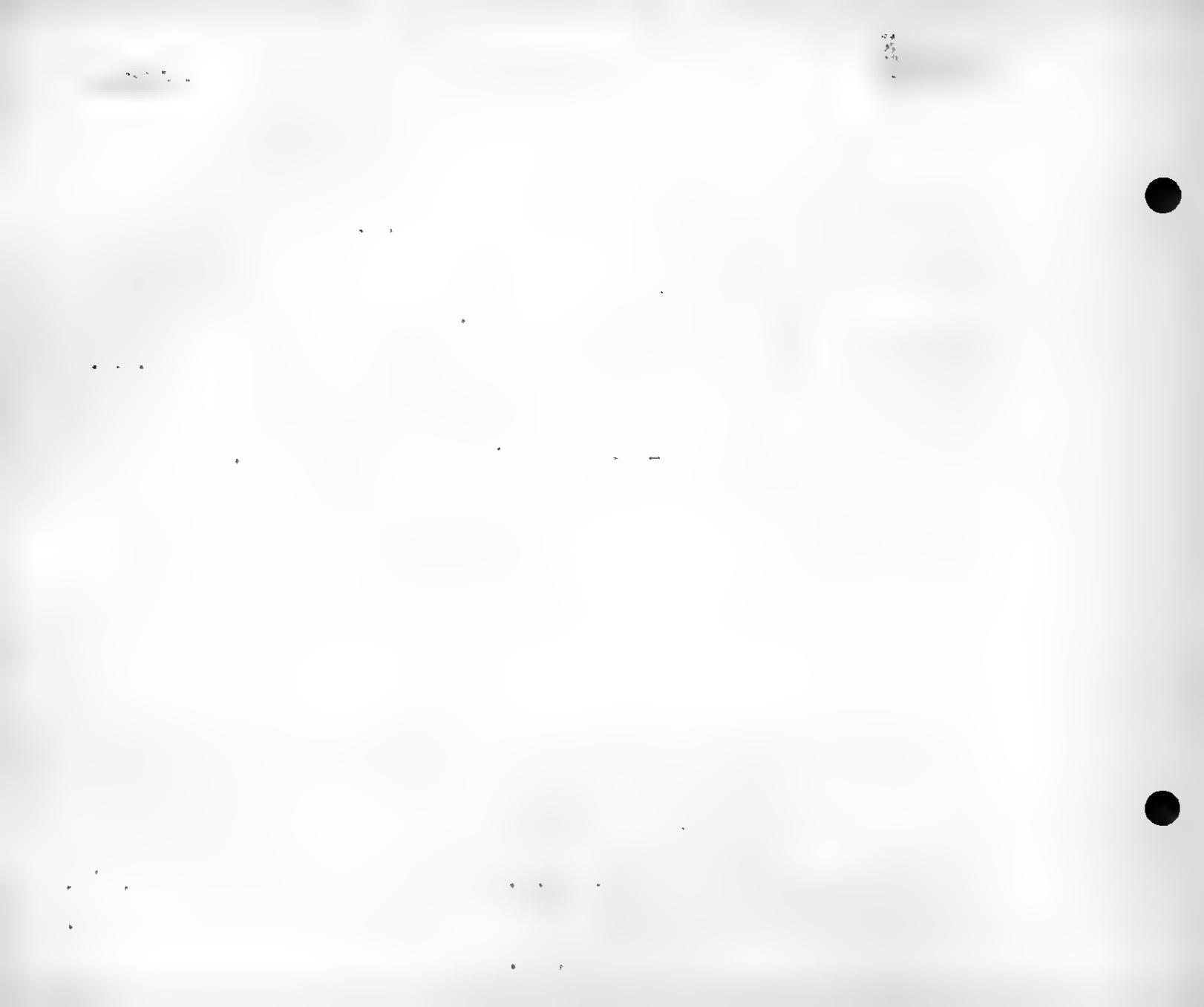
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00027

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a. STATE Maryland		f. INSTITUTION: Residence before admission b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Barton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial		d. STREET ADDRESS R.D. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry		First	Middle	4. DATE OF DEATH Green	Month January	Day 25	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 2, 1905	9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0 Min. 0
10a. OCCUPATION (Give kind of work done during last 6 months of working life even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Green		14. MOTHER'S MAIDEN NAME Alda Broadwater		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-01-7232		17. INFORMANT Grace Green-Barton, Md.		INTERVAL BETWEEN ONSET AND DEATH 6 Days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053.0 DUE TO Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) (c) DUE TO Streptococcal Septicemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.					
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED January 26, 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/28/67	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill	23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.			
24. FUNERAL DIRECTOR <i>Carl Black</i>		ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15ME (5) 6M 1/66		DATE JAN 30 1967					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

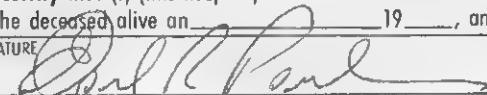
00028

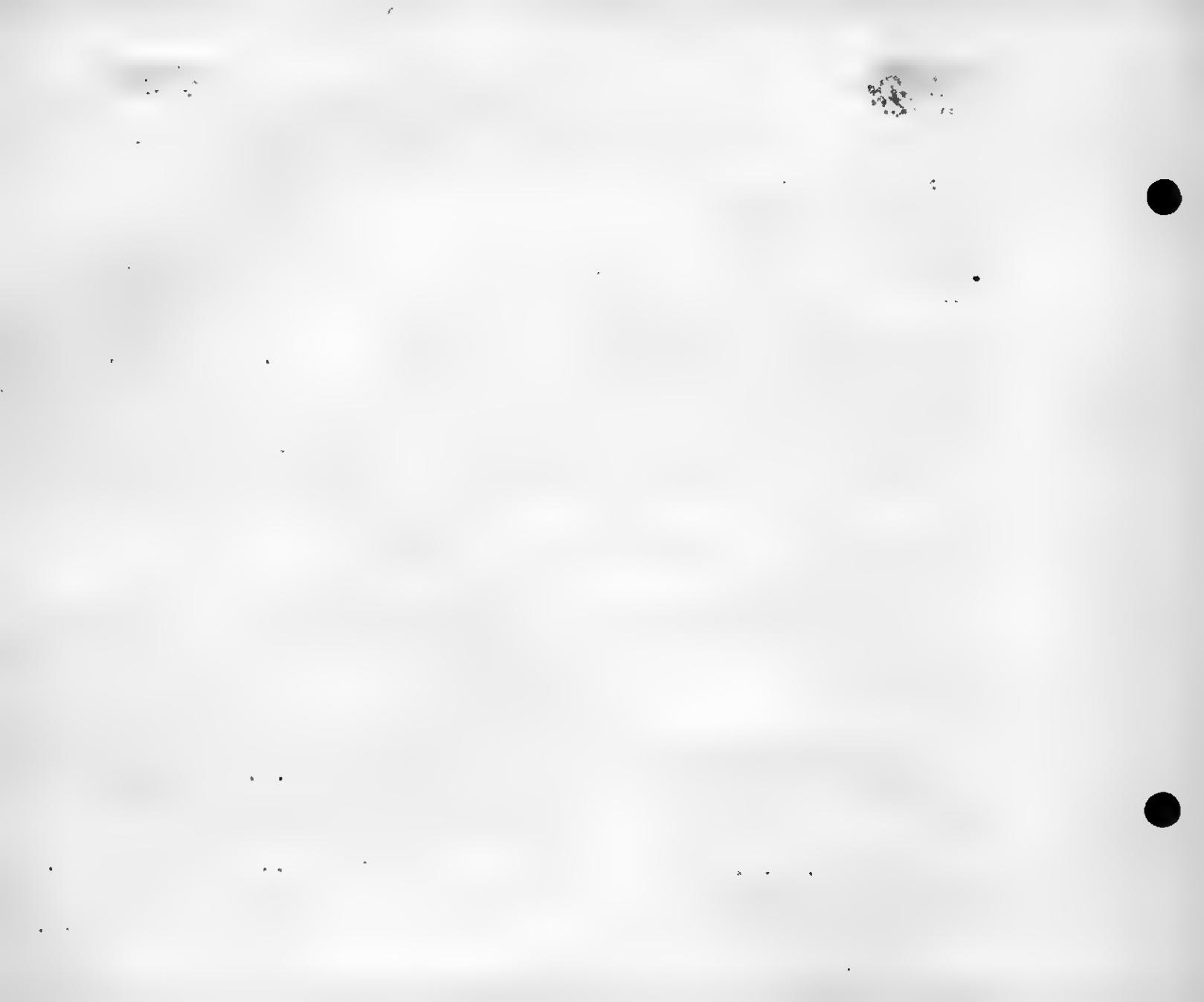
CERTIFICATE OF DEATH

00028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND.		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN Tb 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS COUNTY HOME	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EARL D. GRIM		First EARL	Middle D.
4. DATE OF DEATH JANUARY 26 1967		Lost GRIM	Month JANUARY
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT		10b. KIND OF BUSINESS OR INDUSTRY COUNTY HOME	
11. BIRTHPLACE (County & State, or foreign country) WINCHESTER, VA.		9. AGE (In years last birthday) yrs. 60	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT GRIM	
14. MOTHER'S MAIDEN NAME CATHERINE NAUSSETT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No	
16. SOCIAL SECURITY NO. 226-09-8944		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pneumonia			
DUE TO (b) Recurrent metastatic carcinoma			
DUE TO (c) from colon			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 36 GREENE ST., CUMBERLAND, MD.
20f. (City or town) CUMBERLAND		(County) ALLEGANY	
(State) MARYLAND			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE 		22b. ADDRESS	
22c. PHYSICIAN'S NAME (Type) DR. E.R. PAUL		22d. ADDRESS 36 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park
23d. LOCATION (City or Town) CUMBERLAND		(County) ALLEGANY	
(State) MARYLAND			
24. FUNERAL DIRECTOR William G. Kight		25a. REC'D. BY REGISTRAR FEB 1 1967	25b. REGISTRAR'S SIGNATURE 



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 15 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MABELLE		First MABELLE	Middle C.	Last GRIM	4. DATE OF DEATH JAN. 13, 1967	Month JAN.	Day 13	Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1916	9. AGE (In years, last birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) CHAMBERSBURG, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME EDWARD SNYDER		14. MOTHER'S MAIDEN NAME MARY SITES							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 170X		DUE TO L 24				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO 							
(c)		DUE TO 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) 	(County) 	(State) 			
21. I certify that (I) (this hospital) attended the deceased from 19-45 P.M. to 19-45 P.M. , that (I) (we) last saw the deceased alive on 19-45 P.M. , and that death occurred at 19-45 P.M. from causes and on the date stated above.									
22a. SIGNATURE <i>DR. CARLTON BRINSFIELD</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED JAN 17 1967			
22c. PHYSICIAN'S NAME (Type) DR. CARLTON BRINSFIELD		22d. ADDRESS 401 DECATUR ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 16, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Kauffman Station Cem.	23d. LOCATION (City or Town) Green Castle, Pa.		(County) 			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS 		25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE Charles Judge	(State) 			
				DATE JAN 17 1967					



FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00030

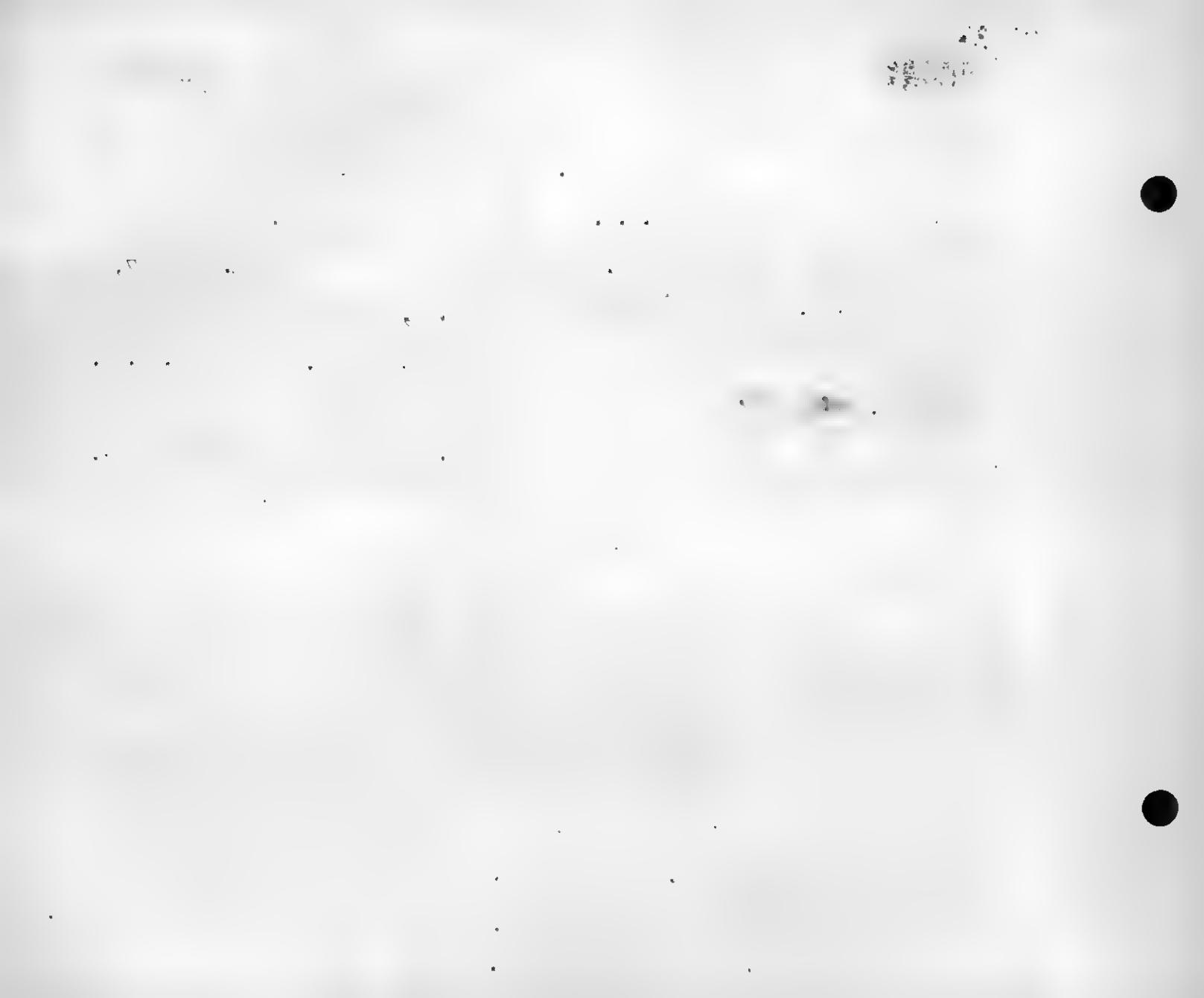
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00030

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If inst. tut.: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		D.O.A. D.O.A.		d. STREET ADDRESS 632 Fairview Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sarah	Middle J.	Last Hayes	4. DATE OF DEATH Jan. 19 1967	Month Jan.	Day 19	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1887	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Midothian Md.		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William, [REDACTED] Hill.		14. MOTHER'S MAIDEN NAME Mary Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. Aden E. Hayes	
				17. INFORMANT Aden E. Hayes		Address 632 Fairview Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/20/1 (b) Coronary Sclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive Cardiovascular disease							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> Benedict Skitarelic							
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan 17, 1967							
22. DATE SIGNED Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/67		23c. NAME OF CEMETERY OR CREMATORIUM Sunset Memo. Park		23d. LOCATION (City, town or county) Cumberland	
(State) Md.							
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumberland Md.		25a. REC'D BY REGISTRAR JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00031

CERTIFICATE OF DEATH

00031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Item 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 2 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			e. STREET ADDRESS 209 PIEDMONT AVENUE		
3. NAME OF DECEASED (Type or print) First LEVI Middle M. Last HENRY			4. DATE OF DEATH JANUARY 18 1967		
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-94	9. AGE (in years lost b. day) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Textile		
11. BIRTHPLACE (County & State, or foreign country) Great W. VIRGINIA Cacapon			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES HENRY			14. MOTHER'S MAIDEN NAME ALICE WHISNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No			16. SOCIAL SECURITY NO		
17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 <i>Carcinoma of colon with metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>to liver</i> (c) <i>Terminal Cachexia</i>					
INTERVAL BETWEEN ONSET AND DEATH 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1000A	(County) CUMBERLAND (State) MD.
21. I certify that (I) (this hospital) attended the deceased from November 1965 , to Jan 18, 1967 , that (I) (we) last saw the deceased alive on Jan 18, 1967 , and that death occurred at 1000A M, from causes and on the date stated above.					
22a. SIGNATURE <i>Wylie M. Faw Jr</i>			22b. DATE SIGNED Jan 19, 1967		
22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW JR.			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD		
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00032

CERTIFICATE OF DEATH

00032

1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

SACRED H EART HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First
JAMES

Middle
Adam

Last
HERSH

4. DATE
OF
DEATH
JANUARY 23 19 67

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR IF UNDER 24 HRS.

MALE

WHITE

WIDOWED

DIVORCED

10/16/06

60

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Promotion work (Sales)

10b. KIND OF BUSINESS OR INDUSTRY

Gas Co.

11. BIRTHPLACE (County & State, or foreign country)

Penna. Meyersdale

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Adam Hersh (deceased)

14. MOTHER'S MAIDEN NAME

Martha Sipple (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

Yes

16. SOCIAL SECURITY NO.

282-09-9816

17. INFORMANT

Address

Mrs. Agnes Hersh 310 Piedmont Ave. Cumb. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

acute coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

OUE TO

(b)

coronary sclerosis

Cumb.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-8-67 to 1-23-67, that (I) (we) last
saw the deceased alive on 1-23-67, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

L. Brings

M.D.
ATTENDING
PHYS.

M.D.
DIRECTOR

STAFF
PHYS.

22b. DATE SIGNED

1-25-67

22c. PHYSICIAN'S
NAME (Type)

Dr. L. Brings

22d. ADDRESS

Greene St., Cumberland, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/26/67

23c. NAME OF CEMETERY OR CREMATORIUM

Hillcrest Burial Park

23d. LOCATION (City, town or county) (State)

Cumberland, Allegany Md.

24. FUNERAL DIRECTOR

H. Wayne George

ADDRESS

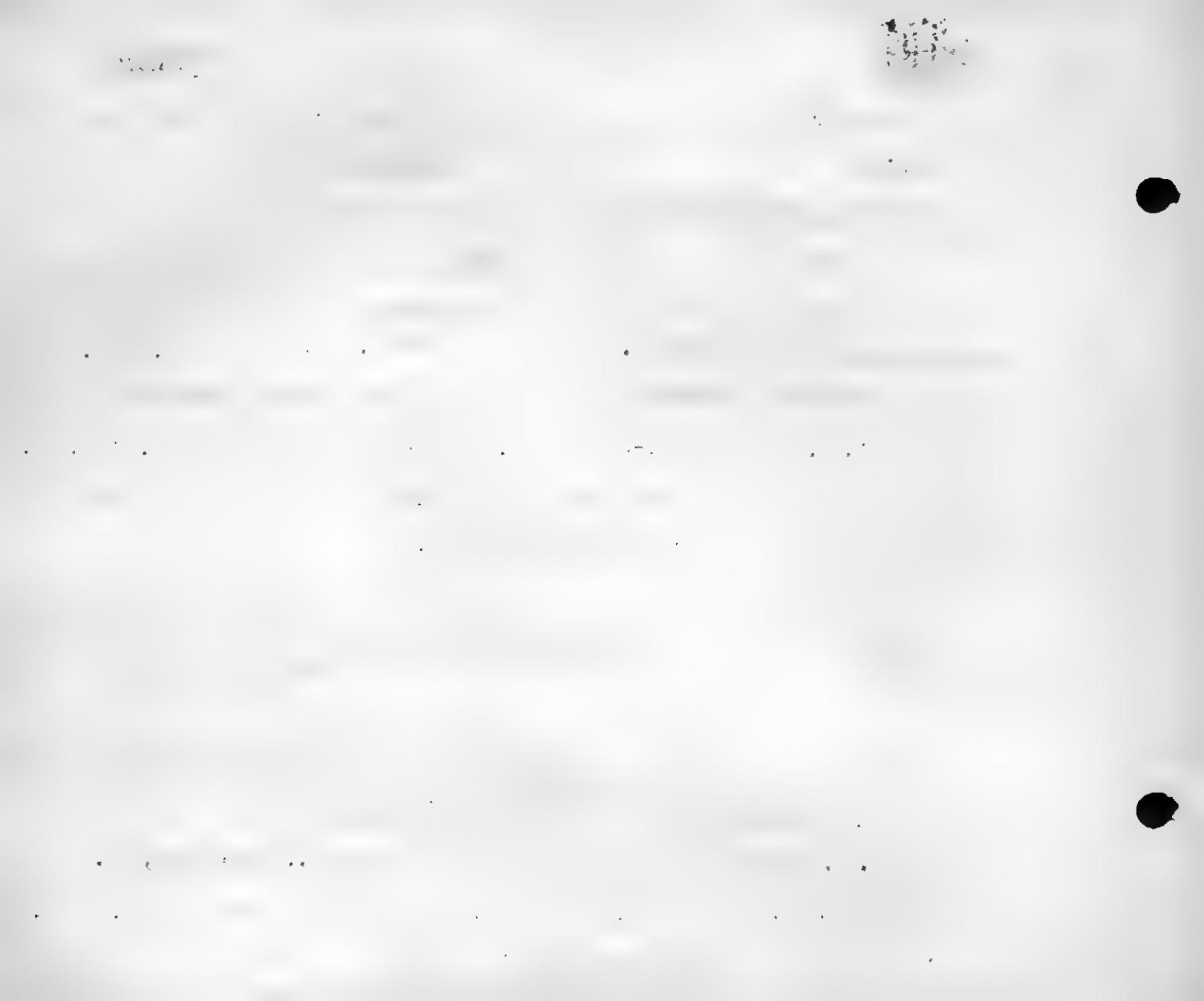
Cumberland, Maryland

25a. REC'D BY REGISTRAR

JAN 27 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00033

Item 8 Film 3534 1/19/67 mh

CERTIFICATE OF DEATH

00033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. If the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLLEGANY Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 16 15 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Arch Street		d. STREET ADDRESS 221 Arch Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frank	Middle Edward	Last Hiles
4. DATE OF DEATH Jan. 11 1967	Month	Doy	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.26.1871 1894
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ice House Employee-Railroad		11. BIRTHPLACE (County & State or foreign country) FULTON COUNTY PENNA.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EDWARD HILES		14. MOTHER'S MAIDEN NAME ALMEDA SPEILMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No or unknown) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. SOCIAL SECURITY NO.	
17. INFORMANT JOSEPH D HILES HANCOCK MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 8 mos	
(b) DUE TO Arteriosclerosis 5 yrs			
(c) DUE TO Chronic myocarditis 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from June 1966, to Jan 11, 1967, that (I) (we) last saw the deceased alive on Jan. 10, 1967, and that death occurred at M, from causes and on the date stated above.		22b. DATE SIGNED Jan. 12, 1967	
22a. SIGNATURE Clay E. Durrett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, MD.		22d. ADDRESS 236 Virginia Ave., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL Spec'd		23b. DATE THEREOF 1.14.67	23c. NAME OF CEMETERY OR Crematory PRESBYTERIAN
24. FUNERAL DIRECTOR Howard & Sonn Hancock Md		ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 16 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

2531



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00034

CERTIFICATE OF DEATH

00034

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN b. 4 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL			d. STREET ADDRESS 75 W. COLLEGE AVE.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle M.	Last JAMES	4. DATE OF DEATH Month JANUARY	Day Year 7, 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 25, 1900	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (County & State, or foreign country) LONACONING, MARYLAND	
13. FATHER'S NAME SAMUEL JAMES			14. MOTHER'S MAIDEN NAME JESSIE McMILLAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-7850		17. INFORMANT FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MyOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY Occlusion 4 days (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) GASTRIC HEMORRHAGE due to PyLORIC ULCER					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 4, 1967 , to JAN. 7, 1967 , that (I) (we) last saw the deceased alive on JAN. 7, 1967 , and that death occurred at 5:25 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>A. Paige Strong</i>					
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, MD.		22d. DATE SIGNED Jan. 7, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 10, 1967		23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK CUMBERLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25. ADDRESS HAFER FUNERAL HOME, 60 W. MAIN		23d. LOCATION (City or Town) (County) (State) MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25. ADDRESS HAFER FUNERAL HOME, 60 W. MAIN		25. REC'D BY REGISTRAR DATE JAN 12 1967	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25. ADDRESS HAFER FUNERAL HOME, 60 W. MAIN		25. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

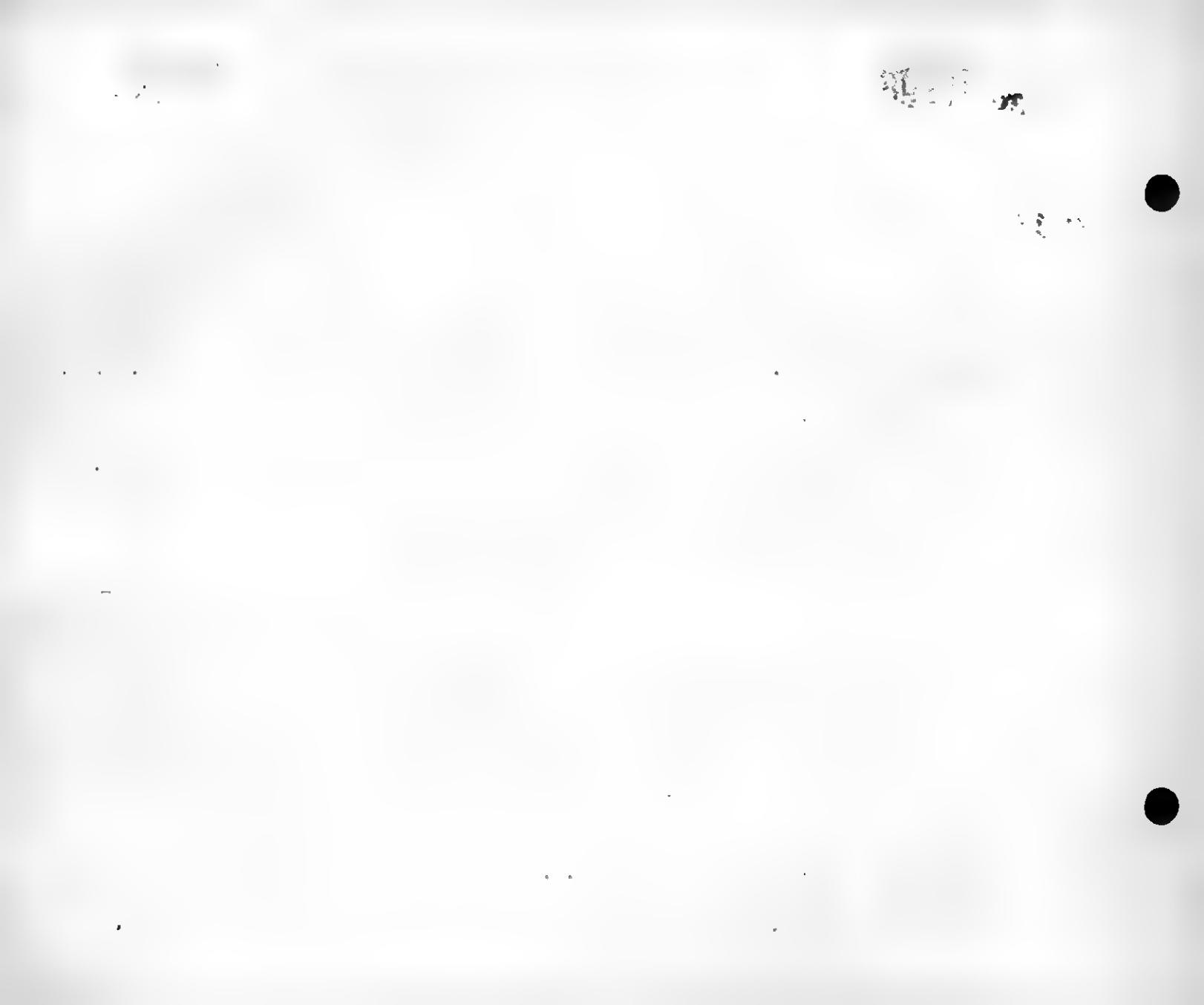
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00035

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00035

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) CUMBERLAND		c LENGTH OF STAY IN lb 72 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1108 HOLLAND STREET	
3. NAME OF DECEASED (Type or print) RAYMOND ROBERT JOHNSTON		First RAYMOND	Middle ROBERT
3. SEX MALE		4. DATE OF DEATH Month JAN. 2	Year 1967
5. COLOR OR RACE WHITE		5. MARRIED WIDOWED	6. NEVER MARRIED DIVORCED
7. MARITAL STATUS WIDOWED		8. DATE OF BIRTH APRIL 29, 1891	
9. AGE (In years last birthday) 72 yrs		F. UNDER 1 YEAR Months 0	I. UNDER 24 HRS Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Lt.		11. BIRTHPLACE (State or foreign country) Cumberland	
12. FATHER'S NAME NATHAN JOHNSTON		13. MOTHER'S MAIDEN NAME MARY JOHNSTON	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service YES W.H.A.		15. SOCIAL SECURITY NO 220-40-1358	
16. INFORMANT RICHARD N. JOHNSTON		17. ADDRESS 1315 Bedford Street Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli, Bilateral DUE TO Cardiac Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) Ischemia, Coronary Disease		19. INTERVAL BETWEEN ONSET AND DEATH DAYS 11	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked anemia		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED January 2, 1966	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan. 5, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ROSEHILL CEMETERY
24. FUNERAL DIRECTOR <i>Bale L. Merritt</i> SILCOX FUNERAL SERVICE		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, Md.	25a. RECEIVED BY REGISTRAR DATE JAN 3 1967
			25b. REGISTRAR'S SIGNATURE <i>Gilcrease Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00036

CERTIFICATE OF DEATH

00036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 16 10 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 115 LAING AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANNA		First MAE	Middle KEISTER	Last	4. DATE OF DEATH JANUARY 28 1967	Month Day Year
S SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-02	9. AGE (In years last birthday) 64 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State or foreign country) ECKHART, MARYLAND			12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME LEWIS, ABRAHAM			14. MOTHER'S MAIDEN NAME MARTHA WILLISON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction, acute, posterior</i> DUE TO <i>wall, due to coronary insufficiency,</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Antecardiac Heart Disease</i>				5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Diabetes</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Obesity</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 1966 to Jan 28, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 28, 1967</i> , and that death occurred at <i>5:00 P.M.</i> from causes and on the date stated above.						22b. DATE SIGNED <i>2 Feb 67</i>
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 31, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Eckhart Cemetery	23d. LOCATION (City or Town) (County) (State) Eckhart, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE B 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G-81 2567 re

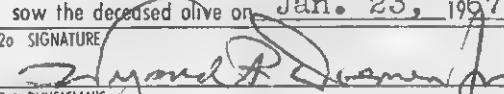
00037

CERTIFICATE OF DEATH

00037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 24 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First TINA	Middle L	Last KENNEDY
4. DATE OF DEATH	Month JAN	Day 23	Year 1967
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 2-25-95	9. AGE (in years at last birthday) 71 12 yrs.	10. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) TEXAS - BROWNWOOD
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME OSCAR COLLY	14. MOTHER'S MAIDEN NAME BONNIE CAIN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO 220-46-9069
17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>Hypertension</u> (b) <u>Stroke with right hemiplegia, acute</u> DUE TO on <u>12-30-66</u> (c) <u>Hypertensive and arteriosclerotic CVD</u> years			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure; cellulitis l. leg; pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30, 1966</u> to <u>January 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1967</u> , and that death occurred at <u>3:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE 	22b. DATE SIGNED 1-26-67		
22c. PHYSICIAN'S NAME (Type) DR. WYAND F. DOERNER JR.	22d. ADDRESS 414 N. MECHANIC ST., CUMB, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 25, 1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

DR



H HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

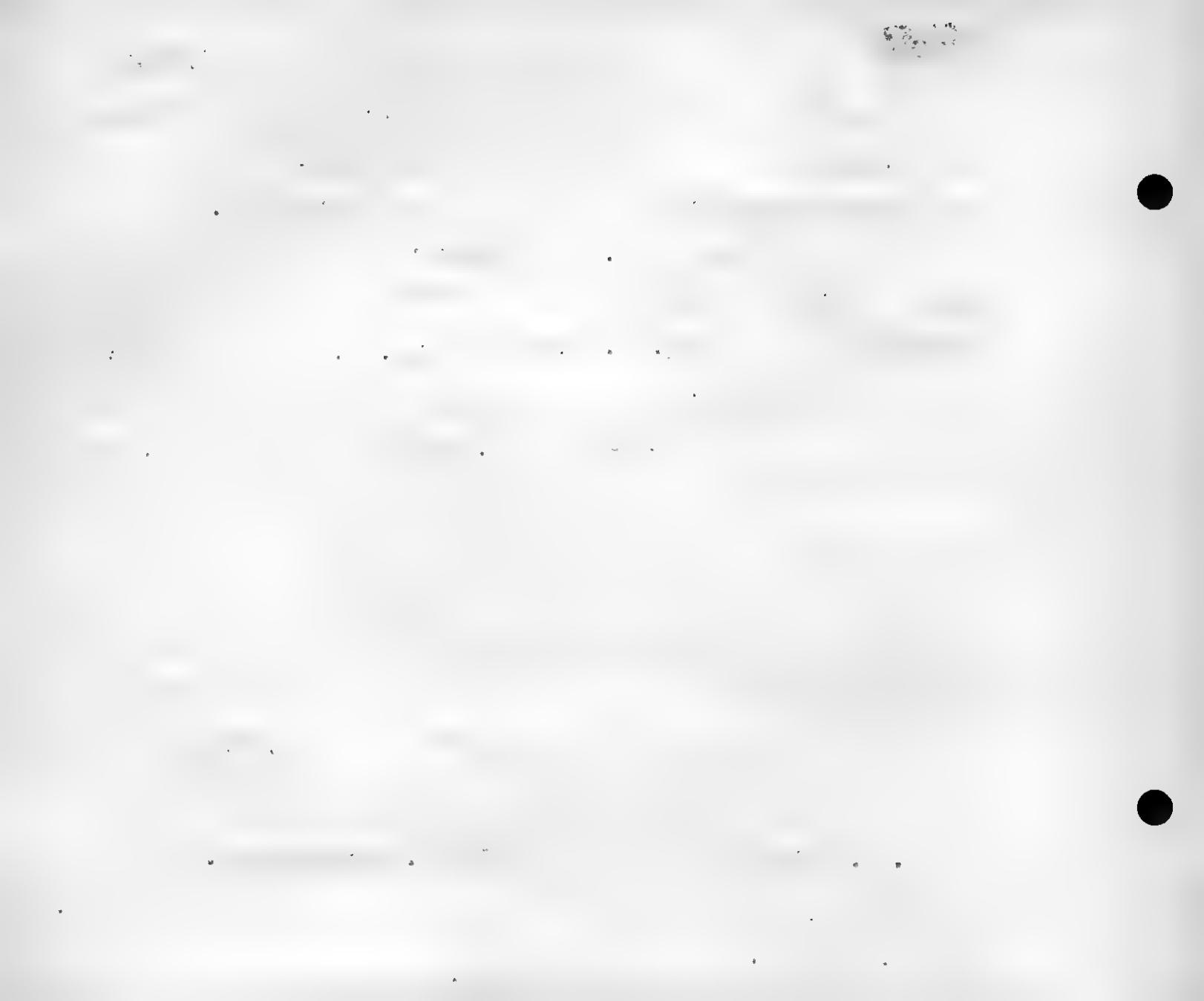
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00038

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Sacred Heart Hospital		d. STREET ADDRESS 407 Washington St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Janet	Middle C.	Last Lancaster
4. DATE OF DEATH	Month 1	Day 10	Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/04
9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 62	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY Alleg. Co. Court House Alleg. Co. Maryland	
11. BIRTHPLACE (County & State, or foreign country) Alleg. Co. Court House Alleg. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert McMurdo		14. MOTHER'S MAIDEN NAME Margaret Askey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-5920	
17. INFORMANT		Address Mrs. Sara Rank, 121 Tilghman St. Cumberland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Megacecal Infarction			
INTERVAL BETWEEN ONSET AND DEATH moment			
120.1 Cconditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/20/65 , 19, to 1/10/67 , 19, that (I) (we) last saw the deceased alive on 1-92 19 67, and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W.C. Spiggle		22b. DATE SIGNED 1-13-67	
22c. PHYSICIAN'S NAME (Type) W. C. Spiggle		22d. ADDRESS 126 N. Smallwood St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 13, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS 230 Baltz Ave., Cumberland	25a. REC'D BY REGISTRAR JAN 16 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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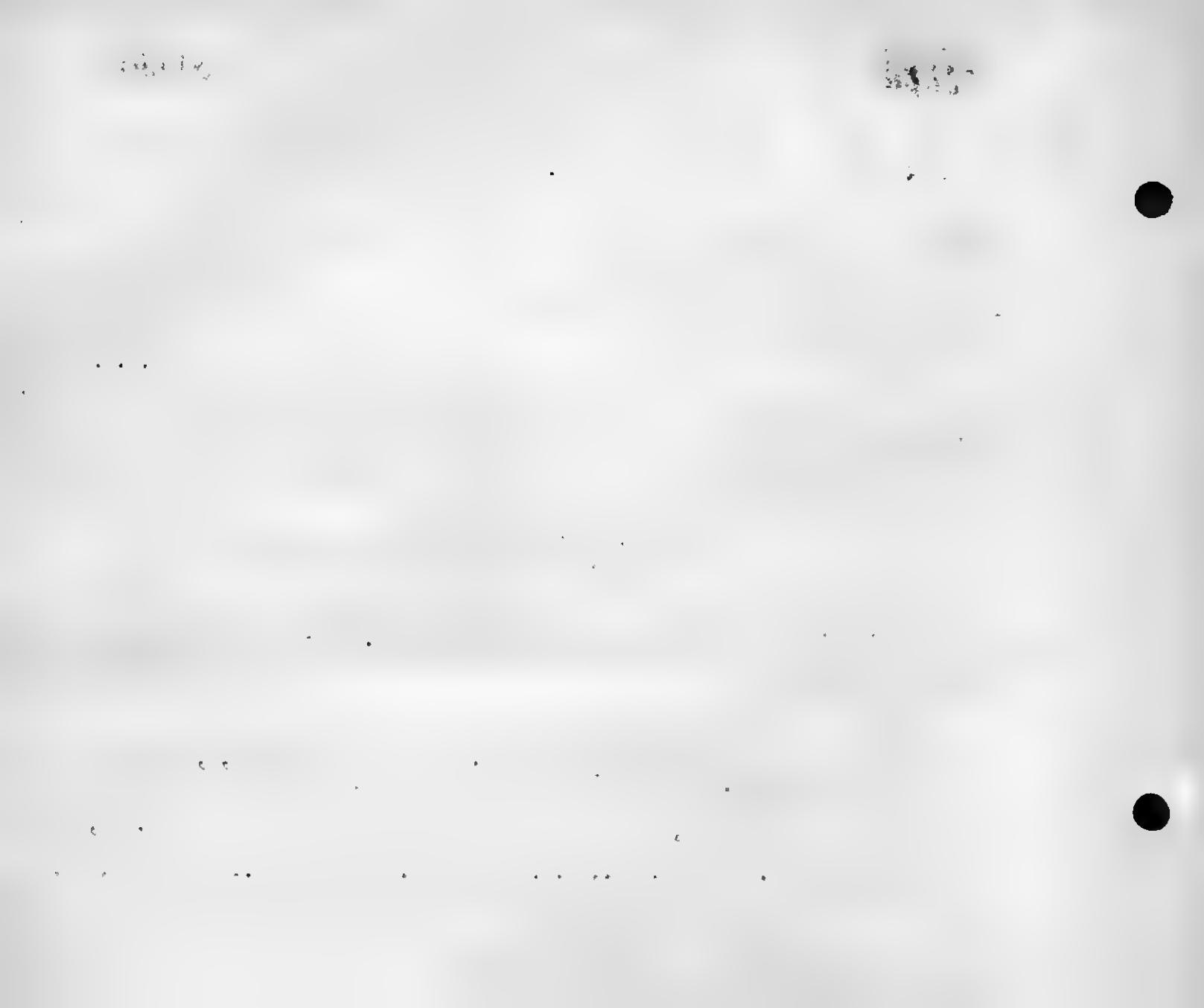
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00039

CERTIFICATE OF DEATH

00039

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1B Cumberland 86 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 520 Bedford Street		e. STREET ADDRESS 208 Park Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Katherine Moore		First	Middle	Last	4. DATE OF DEATH Landis January 28 1967	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1880	9. AGE (In years last birthday) 86 yrs.	10. IF UNDUE 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Moore		14. MOTHER'S MAIDEN NAME Bridget Moore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Matthew Nullaney Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke with cerebral edema 4201 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular and cerebral vascular disease DUE TO (c) Years						INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial infarction with congestive failure Jan. 1966						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 10th, 1966, to Jan 28th, 1967, that (II) (we) last saw the deceased alive on Jan. 27th 1967, and that death occurred at 1:30 p.m. from the causes and on the date stated above.								22b. DATE SIGNED Jan. 31, 1967	
22a. SIGNATURE Wyand F. Doerner, Jr., M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		22d. ADDRESS 1114 N. Mechanic St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/31/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park		23d. LOCATION (City, town or county) Cumberland Maryland		(State)	
24. FUNERAL DIRECTOR Louis Stein Inc		25a. REC'D BY REGISTRAR FEB 2 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge					





MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00040

CERTIFICATE OF DEATH

00040

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 24 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL,		d. STREET ADDRESS 522 LOUISIANA AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First OTTO	Middle M.	Last LAUER
4 DATE OF DEATH JANUARY 18 1967	Month	Day	Year
S SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 10-9-91
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE (In years lost birthday) 75 yrs.
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTANENCE MAN		10b. KIND OF BUSINESS OR INDUSTRY HOTEL	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN LAUER		14. MOTHER'S MAIDEN NAME BLAINE UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 111 09 2514	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension C.V. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 17/67, 12:25 P.M. to Jan 18/67, that (I) (we) last saw the deceased alive on Jan 18/67, and that death occurred at M, from causes and on the date stated above		22b. DATE SIGNED 1/19/67	
22a. SIGNATURE DR. BLANE SCHINDLER		22b. ADDRESS CUMBERLAND, MD.	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR JAN 23 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00043

CERTIFICATE OF DEATH

00041

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rose	Middle P.	Last Lemmert
4. DATE OF DEATH Month 1 Day 3 Year 1967	5. SEX Female	6. COLOR DR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9/7/1896	9. AGE (in years last birthday) 70 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Ranking, W. Va.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elijah Huffman Llewellyn	14. MOTHER'S MAIDEN NAME Julie Keiling	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. 214-03-4024 17. INFORMANT patient's chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ARTEROSCLEROTIC CARDIOVASCULAR DISEASE PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42a.1 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INFARCTION OF ASCENDING GASTRUM 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 1-3 1967 , that (I) witnessed saw the deceased alive on 1-3 1967 , and that death occurred at 145 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Louis Michael Garkovich</i>		22b. DATE SIGNED 1-4-67	
22c. PHYSICIAN'S NAME (Type) Louis Michael Garkovich	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 126 N. Spring St. Frostburg, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-6-67	23c. NAME OF CEMETERY OR CREMATORIAL Fbg. Memorial Park	23d. LOCATION (City, town or county) (State) Frostburg, Md.
24. FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md.	ADDRESS	25a. REC'D BY REGISTRAR JAN 9 1967	25d. REGISTRAR'S SIGNATURE <i>Marie Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
División de STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00042

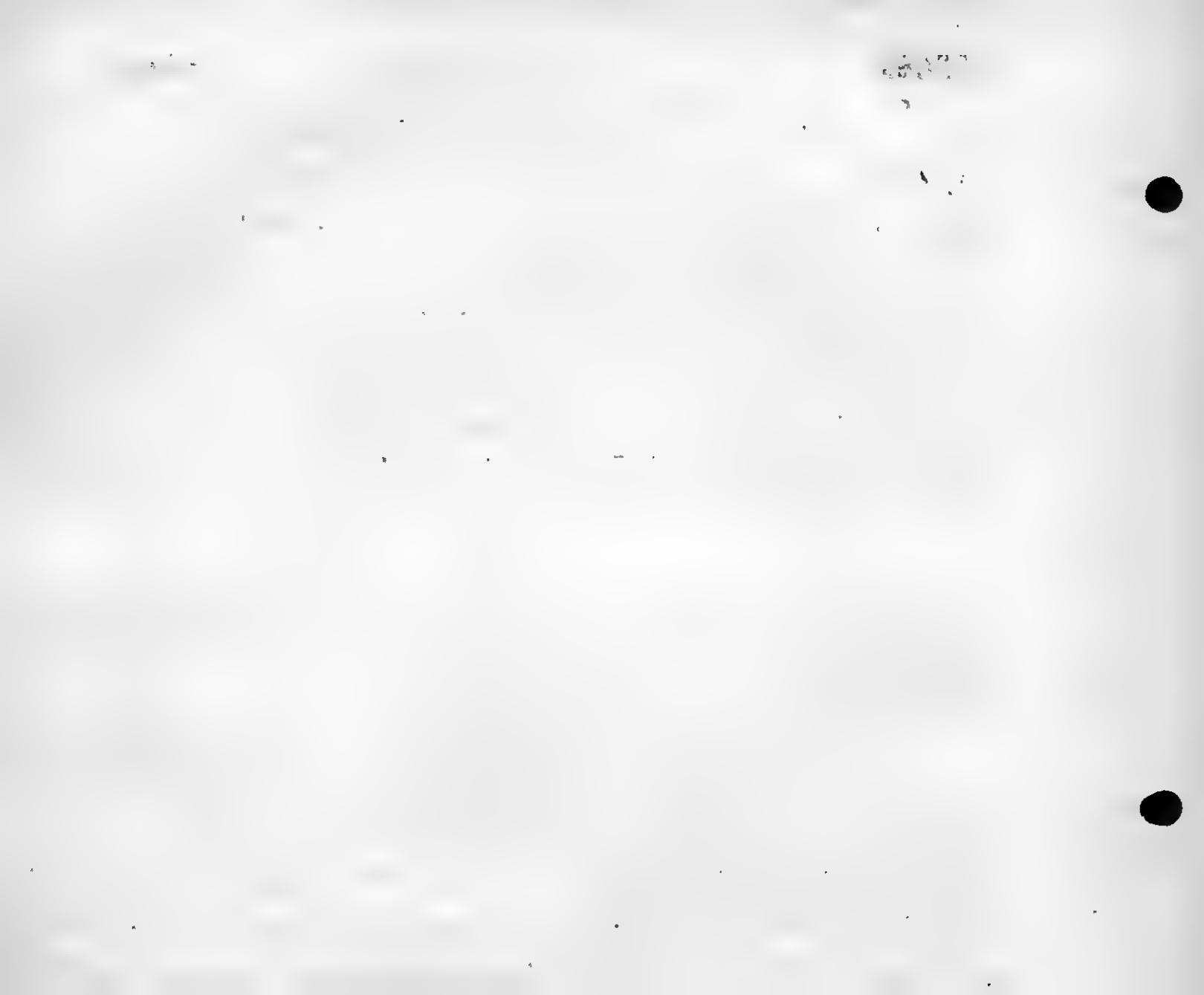
CERTIFICATE OF DEATH

00042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Alleghany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on: Res dence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 79 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 613 St. Mary's Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 613 St. Mary's Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) Alice		First	Middle	4 DATE OF DEATH Jan. 18	Month	Day	Year 19 67	
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 5, 1887	9 AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b KIND OF BUSINESS OR INDUSTRY none		11 BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Lippold				14. MOTHER'S MAIDEN NAME Anna Malone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-48-9024		17. INFORMANT Mrs. Mary L. Owens, Cumberland, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture DUE TO Myocarditis INTERVAL BETWEEN ONSET AND DEATH 5 yrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture R Hip DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on Bricks						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 1/11/1967 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Cumberland		20f. (City or town) Cumberland (County) Allegany (State) MD			
21 I certify that (I) (this hospital) attended the deceased from Jan. 16, 1967 , to Jan. 18, 1967 , that (I) (we) last saw the deceased alive on Jan. 16, 1967 , and that death occurred at M , from causes and on the date stated above.								
22a. SIGNATURE Clay E. Durrett				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 1/19/67			
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.				22d. ADDRESS 236 Virginia Ave., Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR Charles Jusser	25b. REGISTRAR'S SIGNATURE	
						DATE JAN 20 1967		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00043

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 210 GREENE ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM Joseph LOGSDON		4. DATE OF DEATH Month JANUARY 23 Day 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 27, 1900			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Ry.			
11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME STANLEY LOGSDON (D)		14. MOTHER'S MAIDEN NAME MARGARET HELMSTITTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service NO.		16. SOCIAL SECURITY NO. 705-05-5304			
17. INFORMANT Mrs. Helena N. Logsdon 210 Greene St. Cumh. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Abdomen - peritonitis DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mesenteric thrombosis DUE TO ACVD (c) CVA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) History of two CVA's and two coronary occlusions			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 - 9 , 19 59 , to 1 - 23 , 19 67 , that (I) (we) last saw the deceased alive on 1 - 23 19 67 , and that death occurred at 3p M, from the causes and on the date stated above.		22a. SIGNATURE Ralph W. Ballin, M.D.		22b. DATE SIGNED 1 - 23 - 67	
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22d. ADDRESS 62 Greene St. Cumberland, Md. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/67		23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.	
24. FUNERAL DIRECTOR H. Hayne George Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JAN 27 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

13

3f + 1 = 7 - 6 = 1

Since $\gamma \neq 0$

24

$\theta = \pi/2 - \alpha + \beta - \gamma$

$$\Gamma = D + f \quad \frac{\partial^2}{\partial z^2} \gamma = 0$$

$$\Gamma = C + I$$

$$I = \Sigma - I$$

So $I + \Sigma = D + f + C = D + C + f = 0$

X

Since $D + C + f = 0$

1
MFOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00044

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany							
c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pt. # 2 Cumberland, Md.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hosp.		d. STREET ADDRESS Balto. Pk., 6 mi. E. of Cumb.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Franklin Levi May		4. DATE OF DEATH Month Day Year January 20, 1967							
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1917		9. AGE (In years) AT DEATH 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Flintstone, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edward May		14. MOTHER'S MAIDEN NAME Nina Teeter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Catherine May Pt. # 2 Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull; crushed chest; multiple fractures DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Struck by vehicle (s) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Struck by vehicle (s)		20c. TIME OF INJURY Month, Day, Year Hour: 6:15 p.m. Jan. 20, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 40 6 mi. east	
20f. (City or town) (County) (State) Cumberland, Allegany Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Benedict Skitarelic		1/23/67			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Rt. # 9 Cumb. Md.		22. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/67		23c. NAME OF CEMETERY OR CREMATORIUM Glendale Cemetery		23d. LOCATION (City, town or county) Flintstone, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR JAN 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

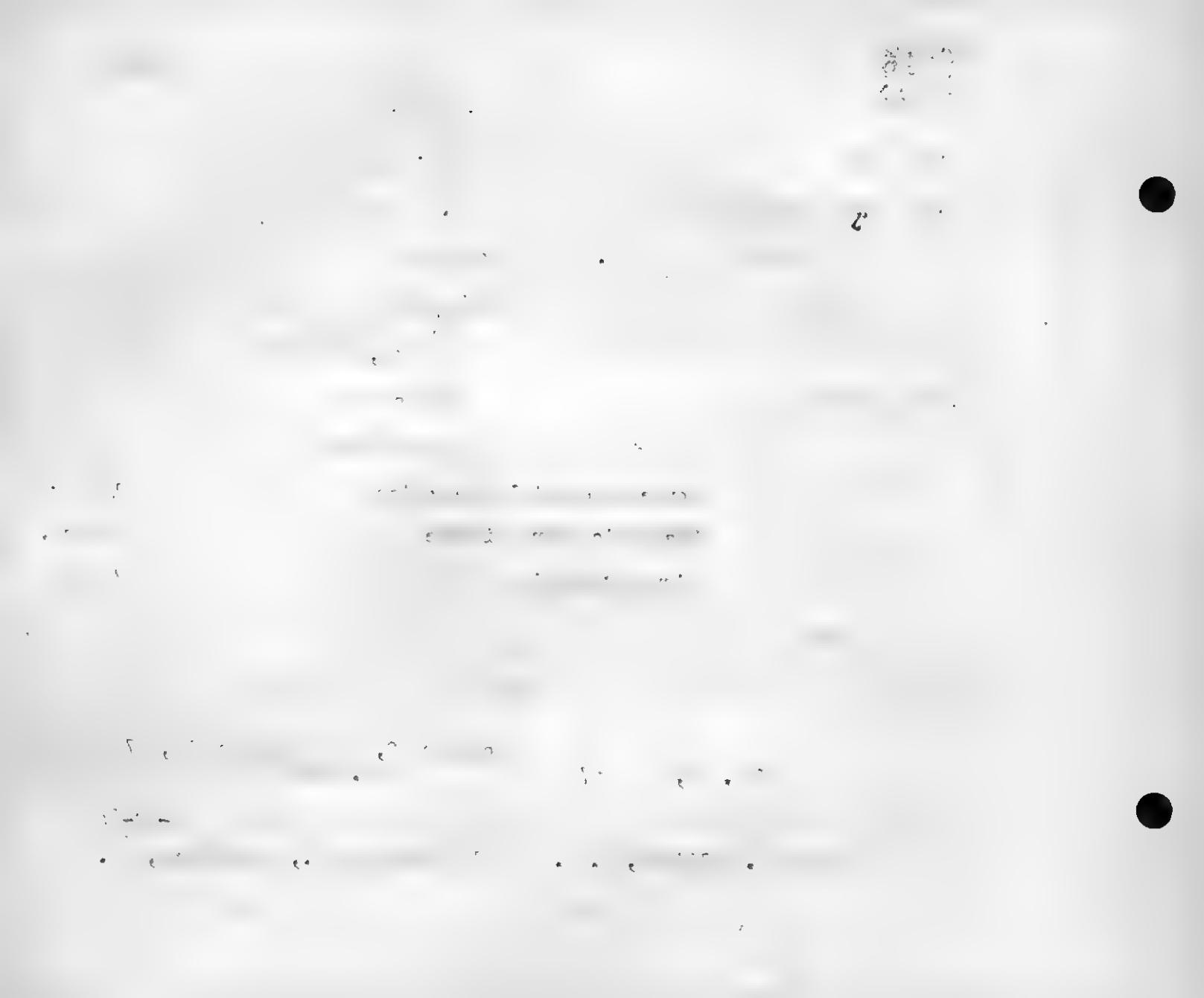
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00045

CERTIFICATE OF DEATH

00045

1. PLACE OF DEATH Allegany	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) MARYLAND Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 13 Days						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital	e. IS RESIDENCE ON A FARM? NO						
3. NAME OF DECEASED (Type or print) Vallie	First V.	Middle McKinley	Last 1	4. DATE OF DEATH 1 18 19 67	Month 1	Day 18	Year 1967
5. SEX F	6. COLOR OR RACE Wht	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/87 1896	9. AGE (In years last birthday) 69 yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diet Kitchen Employee	10b. KIND OF BUSINESS OR INDUSTRY Hosp	11. BIRTHPLACE (County & State, or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Edward Bowman	14. MOTHER'S MAIDEN NAME Viola	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 714-07-6028	17. INFORMANT Patients Chart	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Acute myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 13 days			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Rheumatic heart disease				DUE TO 51 yrs.			
DUE TO Virus pneumonia				DUE TO 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 140 Bedford St., Cumberland, Md.	(County) Md.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from December 22, 1962 , to January 18, 1967 , that (I) (we) last saw the deceased alive on Jan. 18, 1967 , and that death occurred at 10.50 AM . Fill in the causes and on the date stated above.							
22a. SIGNATURE <i>James P. Hallinan Jr.</i>	22b. DATE SIGNED 1-20-67						
22c. PHYSICIAN'S NAME (Type) James P. Hallinan, M. D.	M.D. ATTENDING PHYS. # <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 140 Bedford St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park	23d. LOCATION (City, town or county) (State) Near Cumberland, Md				
24. FUNERAL DIRECTOR John J. Hafer	25a. REC'D BY REGISTRAR JAN 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00046

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00046

1 PLACE OF DEATH a COUNTY Allegany		2 USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
		d STREET ADDRESS 109 Park St.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Last McVicker		First Austin	
4 DATE OF DEATH January 15		Month Year 1967	
5 SEX Male		6 COLOR OR RACE White	
7 MARRIED WIDOWED		8 NEVER MARRIED Divorced	
9 DATE OF BIRTH May 19 1886.		10 AGE (In years last birthday) 80 yrs	
11 BIRTH-PLACE (State or foreign country) PA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William J McVicker		14 MOTHER'S MAIDEN NAME Rose Reitz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16 SOCIAL SECURITY NO 172-18-8664	
17 INFORMANT Mary Louise McVicker		Address 4601 Bayard St Pittsburg 18 PA	
18 CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 430.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Minutes "	
DUE TO Coronary Sclerosis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) 20d INJURY OCCURRED White <input type="checkbox"/> not White <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour am p.m. 19		20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) 20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, had an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 15, 1967 Address (Street, city, town, or county) Cumberland, Maryland	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED	
23a BURIAL CREMATION, REMOVAL (Specify) JAN 17 1967		23b DATE THEREOF JAN 17 1967	
23c NAME OF CEMETERY OR CREMATORIAL FCC Cemetery		23d LOCATION (City or Town) (County) (State) Rockwood Somerset PA	
24 FUNERAL DIRECTOR G. Wilson J. Wood Funeral Home Rockwood		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 616 Broadwater		25b REGISTRAR'S SIGNATURE Charles Judge	
DATE JAN 19 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00047

CERTIFICATE OF DEATH

00047

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE PENNSYLVANIA b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give town) CUMBERLAND			c. LENGTH OF STAY IN lb 2 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) TINA MARIE MERKEL			4. DATE OF DEATH JANUARY 24 1967	Month	Day Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 1-22-1967	9. AGE (In years last b'rthday) yrs. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
			11. BIRTHPLACE (County & State, or foreign country) MEYERSDALE, PA.		
13. FATHER'S NAME CHARLES MERKEL			14. MOTHER'S MAIDEN NAME BETTY BUTLER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO		
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Nervous System Bleeding</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Prematurity</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 2:13 A.M., from causes and on the date stated above.					
22a. SIGNATURE <i>Robert D. Brodell</i>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) DR. ROBERT D. BRODELL		22d. ADDRESS 500 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, BURNED (Specify)		23b. DATE THEREOF Jan. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co., Pa.
24. FUNERAL DIRECTOR <i>Harvey N. Zeigler</i>		ADDRESS Hyndman, PA.		25a. REC'D BY REGISTRAR DATE FEB 1 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00048

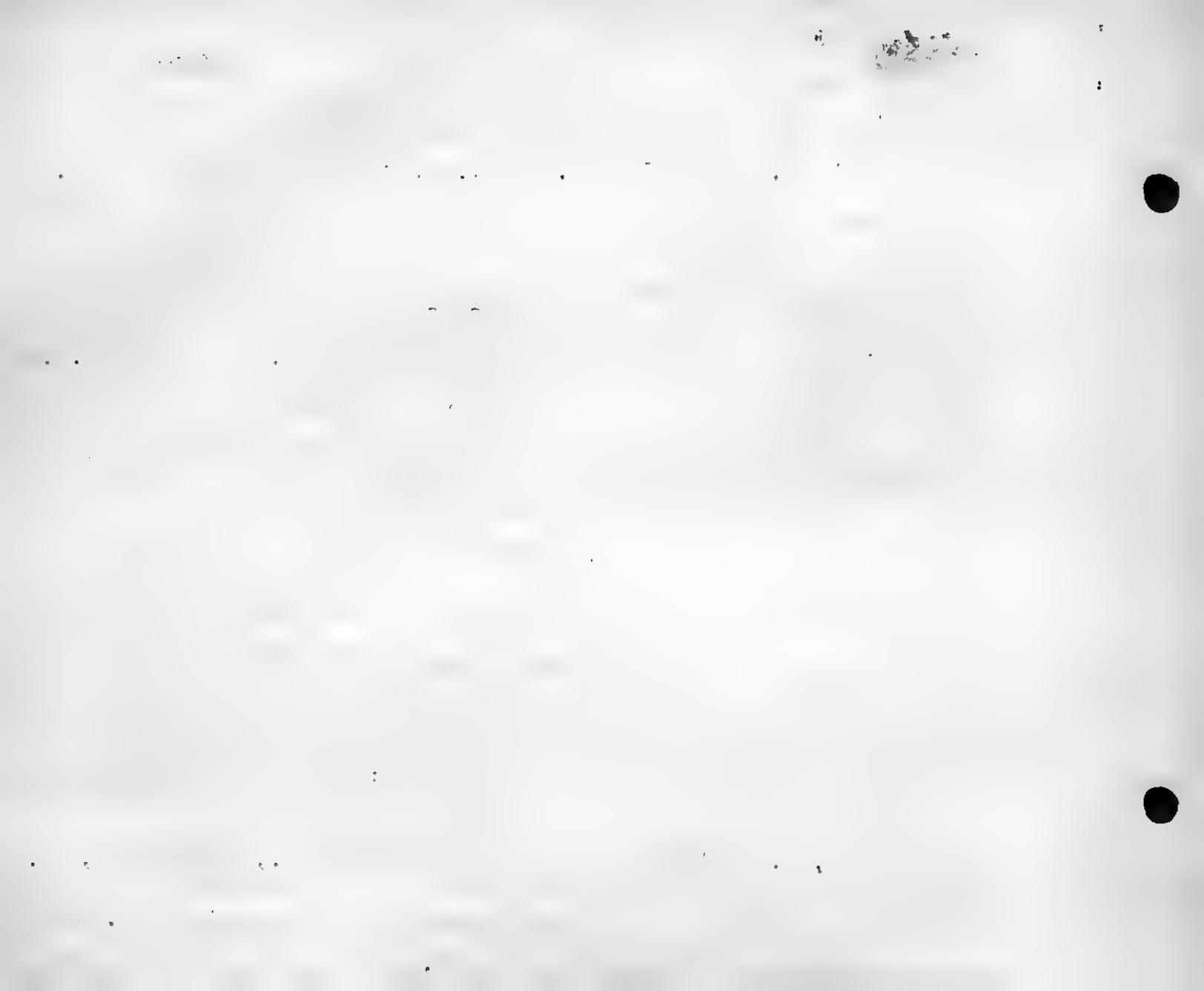
CERTIFICATE OF DEATH

00048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,	c. LENGTH OF STAY IN lb 13 HRS.	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 3, BOX 258, CUMBERLAND, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE	First H	Middle MILLER	4. DATE OF DEATH Month JANUARY Day 8 Year 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-28-1901	9. AGE (In years last birthday) yrs 85	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. US & AL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) LONACONING, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DAVID HOLMES	14. MOTHER'S MAIDEN NAME JEAN DOUGLASS	Address CUMBERLAND, MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lungs Estes may cor pulmonale		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) DUE TO lungs Estes may cor pulmonale			
(c) DUE TO lungs Estes may cor pulmonale			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to June 8, 1967 , that (I) (we) last saw the deceased alive on June 7, 1967 , and that death occurred at 30P.M. from causes and on the date stated above.			
22a. SIGNATURE B. Schindler		22b. DATE SIGNED 1/16/67	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/11/67	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Lonaconing A. Md
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR JAN 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

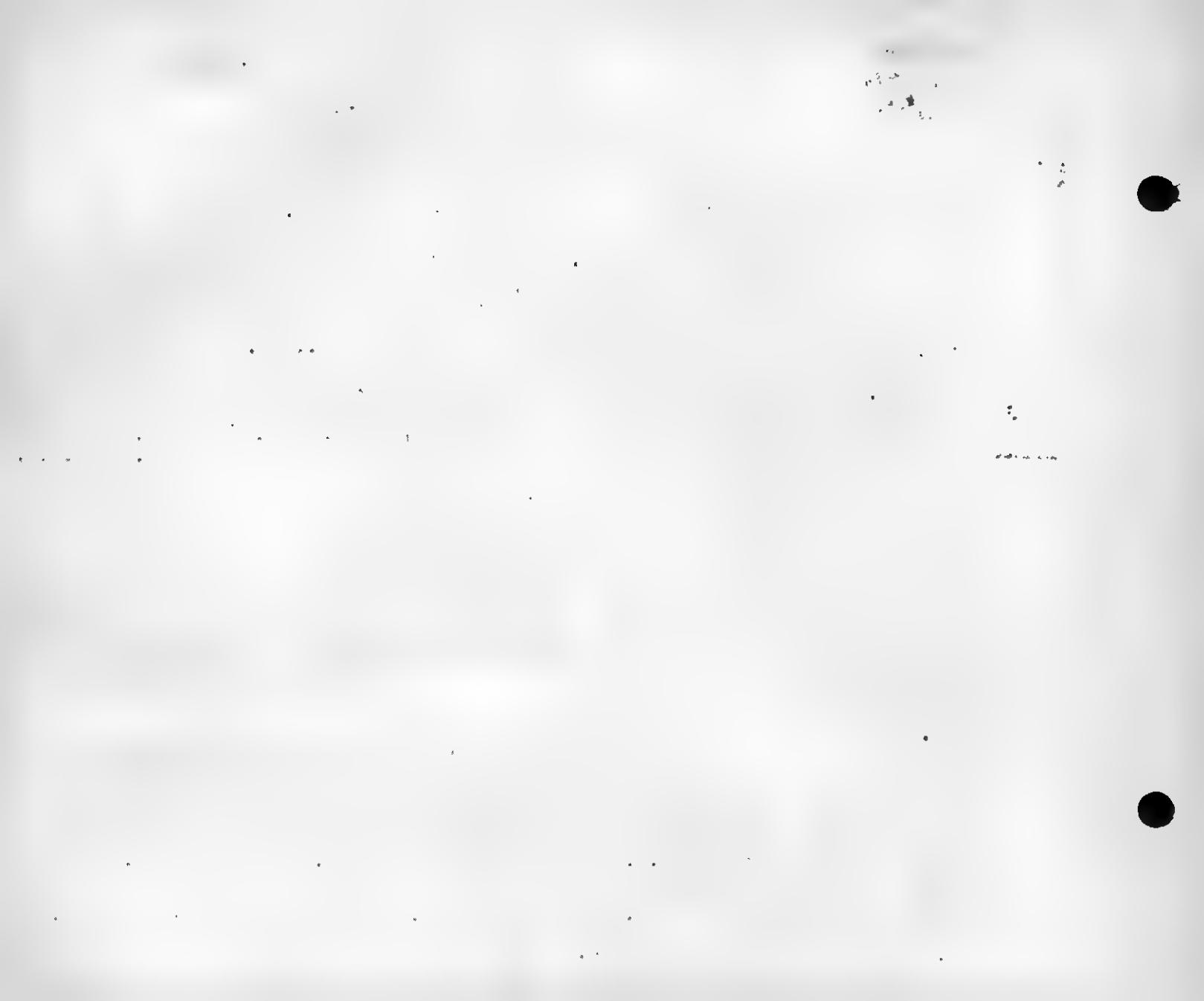
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00049

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 661 Greene St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		g. DATE OF DEATH Month Day Year 1 4 1967	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Miller
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/86
9. AGE (In years last birthday) 80 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Murphy	14. MOTHER'S MAIDEN NAME Mary Scalley Murphy	15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT patient's chart	Address "Mrs. Farard E. Roberts 661 Greene St. Cumb. Md."
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO coronary sclerosis	
DUE TO asthma		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-28 , 19 66 , to 1-4 , 19 67 , that (I) (we) last saw the deceased alive on 1-4 , 19 67 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE lewis brins		22b. DATE SIGNED 1-7-67	
22c. PHYSICIAN'S NAME (Type) lewis Brins, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 57 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 1/7/67	23c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul Cen.
24. FUNERAL DIRECTOR H. Payne George Cumberland, Md.		23d. LOCATION (City, town or county) (State) Cumberland, Allegany Md.	25a. REC'D BY REGISTRAR DATE JAN 10 1967
		25b. REGISTRAR'S SIGNATURE John Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 film 305 1/25/67 mh

CERTIFICATE OF DEATH

00050

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00050

1 PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

FROSTBURG

c. LENGTH OF STAY IN lb

3 WEEKS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MINERS HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

MARYLAND

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

R.F.D. 2, BOX 110

d. STREET ADDRESS

FROSTBURG

e. IS RESIDENCE ON A FARM?

YES NO 3 NAME OF
DECEASED
(Type or print)First
HOWARDMiddle
W.Last
MYERS4. DATE
OF
DEATH

JAN.

17 1967

Year

5 S. SEX

6 COLOR OR RACE

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

9 AGE (in years
last birthday)10. IF UNDER 1 YEAR
Months11. IF UNDER 24 HRS
Days

Hours

Min

MALE

WHITE

WIDOWED

DIVORCED

APRIL 10, 1890

11/76 yrs

10a. USUA. OCCUPATION (Give kind of work done
during most of working life, even if retired)

BOLT & FORGE DEPT.

10b. KIND OF BUSINESS OR
INDUSTRY

B & O RAILROAD

11. BIRTHPLACE (County & State, or foreign country)

ECKHART, MARYLAND

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM MYERS

14. MOTHER'S MAIDEN NAME

SARAH DUDLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes or No; unknown) (If yes give war or dates of service)

YES W.WAR I

16. SOCIAL SECURITY NO.

213-09-6419

17. INFORMANT

MR. PERRY MYERS, ADDRESSEE
FROSTBURG, MD.INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Acute brain syndrome

DUE TO

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.

(b)

DUE TO

(c)

cerebral arteriosclerosis

3 weeks

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

Chronic, subacute arteriosclerotic heart disease

19. WAS AUTOPSY
PERFORMED?YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour o.m.

p.m.

19

20d. INJURY OCCURRED

While

Not While

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1967, to Jan. 17, 1967, that (I) (we) last saw the deceased alive on Jan. 16, 1967, and that death occurred at 3:45 PM, from causes and on the date stated above.

22a. SIGNATURE

S. Paige Strong

M.D. ATTENDING
PHYS MED.
DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

Jan. 19, 1967

22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

167 E. MAIN ST. - FROSTBURG, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City or Town)

(County)

(State)

BURIAL

JAN. 19, 1967

ECKHART CEMETERY

ECKHART

MARYLAND

CREMATION

ADDRESS

MARILOU SOWERS HAFER FUNERAL HOME

REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

REMOVAL

60 W. MAIN, FROSTBURG

MARYLAND

DATE

JAN 23 1967

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00051

CERTIFICATE OF DEATH

00051

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL, CUMB. MD.			d. STREET ADDRESS 1101 BRADDOCK RD.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) OLA		First R.	Middle NAZELROD	Last JANUARY 18,	DATE Month 19 67
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1916	9. AGE (In years last birthday) 50 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
13. FATHER'S NAME WALTER NAZELROD			14. MOTHER'S MAIDEN NAME MYRTLE ALT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. 214-07-3290		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesostatic adeno carcinoma 154X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) Adeno carcinoma of rectum DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastritis					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Beth	(County) (State) 1967
21. I certify that (I) (this hospital) attended the deceased from 1-17 , 1967, to 1-17 , 1967, that (I) (we) last saw the deceased alive on 1-17 , 1967, and that death occurred at 3:35 AM from causes and on the date stated above.					
22a. SIGNATURE DR. JOSE VALDES		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-18-67
22c. PHYSICIAN'S NAME (Type) DR. JOSE VALDES		22d. ADDRESS AL GONQUIN HOTEL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 20, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Nazelrod Cemetery	23d. LOCATION (City or Town) Near Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS 1230 Main St. Cumberland	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE JAN 20 1967	
VR A15 (4) 20 M 1/66					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00052

CERTIFICATE OF DEATH

00052
Reg. Day No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>	
d. STREET ADDRESS <i>417 N. Centre St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sillian Often</i>		First <i>Sillian</i>	Middle <i>Lesley</i>
4. DATE OF DEATH Month <i>January</i>		Day <i>4,</i>	Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 20, 1900</i>
9. AGE (In years lost birthday) yrs <i>66</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. meter reader</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>City Water Dept.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Eckhart, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Patrick Often</i>		14. MOTHER'S MAIDEN NAME <i>Anne Kreitzburg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No,</i>		16. SOCIAL SECURITY NO <i>219-03-8838</i>	
17. INFORMANT <i>Mrs. Prema I. Often 417 N. Centre St. Cumb. Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Hypertension & V. Block.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>Years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 4, 1967</i> to <i>January 4, 1967</i> , that I last saw the deceased alive on <i>January 4, 1967</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>43 Greene St.</i>	
ACTUAL SIGNATURE <i>Blane I. Schindler, M.D.</i>		DATE SIGNED <i>January 5, 1967</i>	
PHYSICIAN'S NAME (Type) <i>Blane I. Schindler, M.D.</i>		CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/7/67</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Sunset Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Allegany, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Wayne George Cumberland, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 10 1967</i>	24b. REGISTRAR'S SIGNATURE <i>McWayne Judge</i>



3-1
FOR STATE
HEALTH DERT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any document is necessary, please execute it on a separate sheet, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00053

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00053

1. PLACE OF DEATH
a. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

3. NAME OF
DECEASED
(Type or print)First
Gilbert

Middle

Last

4. DATE

OF

DEATH

January 26, 1967

Month

Day

Year
19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

October 31, 1906

9. AGE (In years
at birth)

60

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Carpentry

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Magdalene Pfitzenmayer

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

214-07-5313

17. INFORMANT

Mrs. Helen Pfitzenmayer, Ellerslie, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

Coronary sclerosis

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

(County)

(State)

White

Not White

at work at work 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opiniondeath resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

1/26.67

Cumberland, RD#9, Md.

22a. BURIAL, CREMATION,

REMOVAL (Specify)

Burial

22b. DATE THEREOF

Jan. 29, 1967

22c. NAME OF CEMETERY OR CREMATORIUM

Rest Lawn Memorial Gardens

22d. LOCATION (City, town, or country)

Cash Valley Road, LaVale, Md.

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

FEB 1

1967

24b. REGISTRATION SIGNATURE

Judge



M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00054

CERTIFICATE OF DEATH

00054

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may be filed within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS 905 Glenwood Street	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED First Matilda Middle Emily Last Rodney		4. DATE OF DEATH Month January Day 27 Year 1967	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Dec. 4, 1883 9. AGE (In years lost birthday) 83 yrs	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salad Dietician		10b. KIND OF BUSINESS OR INDUSTRY Sheehe Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James R. Rodney		14. MOTHER'S MAIDEN NAME Annie Wise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-8593 17. INFORMANT Sally C. Moats, 924 Glenwood St. Cumberland	
Address Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis, char. degenerative, cerebral</i>		INTERVAL BETWEEN ONSET AND DEATH	
4/21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis, general cerebral</i> DUE TO (c) <i>1/17/21 Presenile Artery Disease</i> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>E psychotic Reaction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 5, 1959, to Jan. 21, 1967, that (I) (we) last saw the deceased alive on Jan. 26, 1967, and that death occurred at 8 A.M. from causes and on the date stated above.		22b. DATE SIGNED 1/27/67	
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene Street, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 30, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Patrick's Cath. Com.		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg. Md	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR DATE: 30 1967	
John J. Hafer, Jr., 230 Baltip Ave. Cumberland		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00055

CERTIFICATE OF DEATH

00055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS 156 Polk St.	
3. NAME OF DECEASED (Type or print) CHARLES W. SHAFFER		4. DATE OF DEATH 1/2/1967	Month Day Year
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
13. FATHER'S NAME Charles Shaffer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 712-14-1671-A	
17. INFORMANT Pt's chart.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - renal - vascular disease			
DUE TO 4/2/67			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) arteriosclerosis			
DUE TO 2 years			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2/67 , to 1/2/67 , that (I) (we) last saw the deceased alive on 1/1/67 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE L. L. Brings		22b. DATE SIGNED 1/2/67	
22c. PHYSICIAN'S NAME (Type) L. L. Brings, M.D.		22d. ADDRESS 57 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY HYNDMAN CEMETERY		23d. LOCATION (City, town or county) (State) HYNDMAN, PA.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR JAN 6 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judd	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00056

CERTIFICATE OF DEATH

00056

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

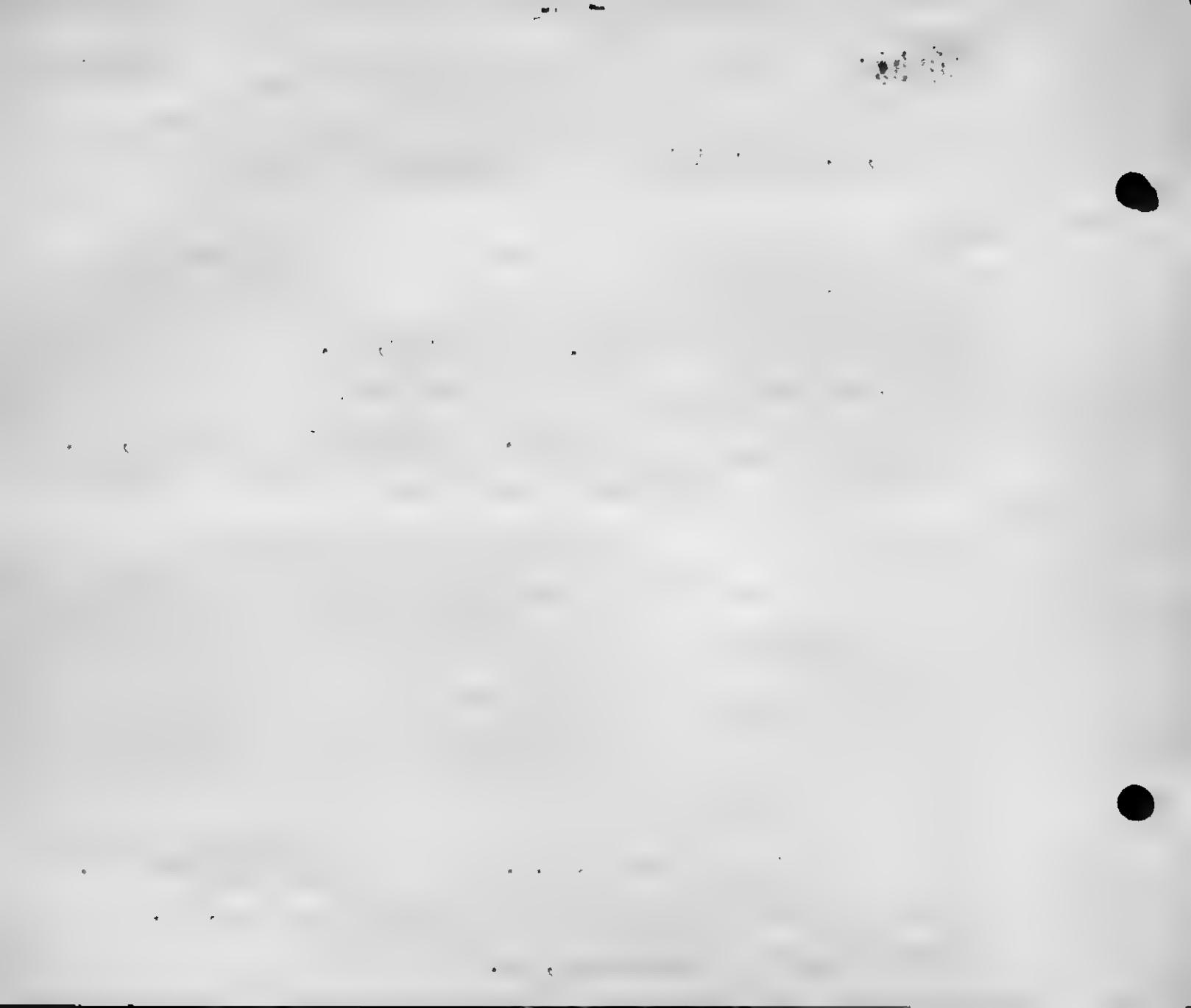
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 59 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale	
3. NAME OF DECEASED (Type or print) Anne K. Sheakley		d. STREET ADDRESS 9 Asbury Avenue	
3. NAME OF DECEASED (Type or print) Anne K. Sheakley		4. DATE OF DEATH 1 6 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/07
10a. USUAL OCCUPATION (Give kind of work done during master working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 59 yrs
13. FATHER'S NAME John Dailey		11. BIRTHPLACE (County & State or foreign country) Allegany Co., Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-0141	17. INFORMANT Patient's chart
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>test!</i>		<i>Acute cardiac dilatation & failure</i> minutes	
(b) DUE TO		<i>Atherosclerotic C.V. heart disease</i> 4 yrs	
(c) DUE TO		<i>Cirrhosis of liver</i> 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetic Mellitus. Carcinoma right breast & pleural effusion</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/20/64 , to Jan 5, 1967 , that (I) (we) last saw the deceased alive on Jan 5, 1967 , and that death occurred at 6:30 AM , from causes and on the date stated above.		22b. DATE SIGNED 1/16/67	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas F. Lewis, M.D.		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 500 Greene St., Cumberland, Md.
23a. BURIAL, CREMATION, BREMOLAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 11 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



1
M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Give Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
ITEMS 8, 9, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 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1410, 1411, 1412, 1413, 1414, 1415, 1											



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00058

CERTIFICATE OF DEATH

00058

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 16 41 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 106 CRESAP DR., BOWLING BK		
e. NAME OF DECEASED (Type or print) CHARLES W. SMITH		f. DATE OF DEATH JANUARY 17 1967		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1889	9. AGE (In years last birthday) 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (County & State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME SMITH, ADDISON			14. MOTHER'S MAIDEN NAME MARY REBECCA PARELL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 10 2438		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Generalized Arteriosclerosis</i> INTERVA. BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterial Disease</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour p.m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 117	20f. (City or town) Cumberland	(County) (State) Md.
21. I certify that (I) (this hospital) attended the deceased from 1/17/67, 1967, to 1/17/67, 1967, that (I) (we) last saw the deceased alive on 1/16/67, 1967, and that death occurred at 2:45 P.M. from causes and on the date stated above					
22a. SIGNATURE <i>R.J. Williams</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1/17/67
22c. PHYSICIAN'S NAME/(Type) DR. R.J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL PORTER CEMETERY		23d. LOCATION (City or Town) ECKHART, MD. (County) (State)
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. RECD BY REGISTRAR JAN 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00059

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b c. STREET ADDRESS Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS Church Street	
3 NAME OF DECEASED (Type or print)	First JENNIE	Middle SMITH	4. DATE OF DEATH 1/23/1967
3 SEX Female	5 COLOR OR RACE White	6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MONTH 19 Day 19 Year 19
8. DATE OF BIRTH Feb. 17th. 1895		9. AGE (in years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, MD.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel James		14. MOTHER'S MAIDEN NAME Jessie MacMillan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO.	
17. INFORMANT Burton Smith		Address Lonaconing, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Myocardial Ischemia DUE TO Conditions, if any, which gave rise to immediate cause (a). Advanced Arteriosclerosis (b) DUE TO (c) DUE TO stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac Cerebrus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 23 1967, that (I) (we) last saw the deceased alive on Jan 23 1967, and that death occurred at Lonaconing, Md., from causes and on the date stated above.		22b. DATE SIGNED 1-24-67	
22a. SIGNATURE L.R. MILES, JR.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR.		22d. ADDRESS LONA CONING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Memorial Park		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE			
25c. DATE JAN 25 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4/6/1963	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Cumberland	
3. NAME OF DECEASED First Maude Middle Lena Last Smith		f. STREET ADDRESS 1105 Michigan Avenue	
SEX Female White		g. DATE OF DEATH January 2, 1967	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 83 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Warnfordsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Elliott McCullough		14. MOTHER'S MAIDEN NAME Elizabeth Gardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0	
17. INFORMANT P.O. Box 599, Allegany County Infirmary records.		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerosis & neoplasia N.gastroesoph.</i> DUE TO (3) <i>Arteriosclerosis, ch. 4 Neoplasia.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4+1X</i>			
b) <i>Multiple little strokes</i> DUE TO (6) <i>Pelabryal cataracts</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/6/1963, 19, to 1/2/67, 19, that (I) (we) last saw the deceased alive on 12/31/66, 19, and that death occurred at A. M. from causes and on the date stated above. at 6:20 A. M.			
22a. SIGNATURE <i>Mathews</i>		22b. DATE SIGNED 1/3/1967	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Presbyterian Cemetery		23d. LOCATION (City or Town) (County) (State) Warfordsburg, Pa.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS	
		25b. REG'D BY REGISTRAR JAN 9 1967	
		25b. REGISTRAR'S SIGNATURE <i>Scarpelli</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00061

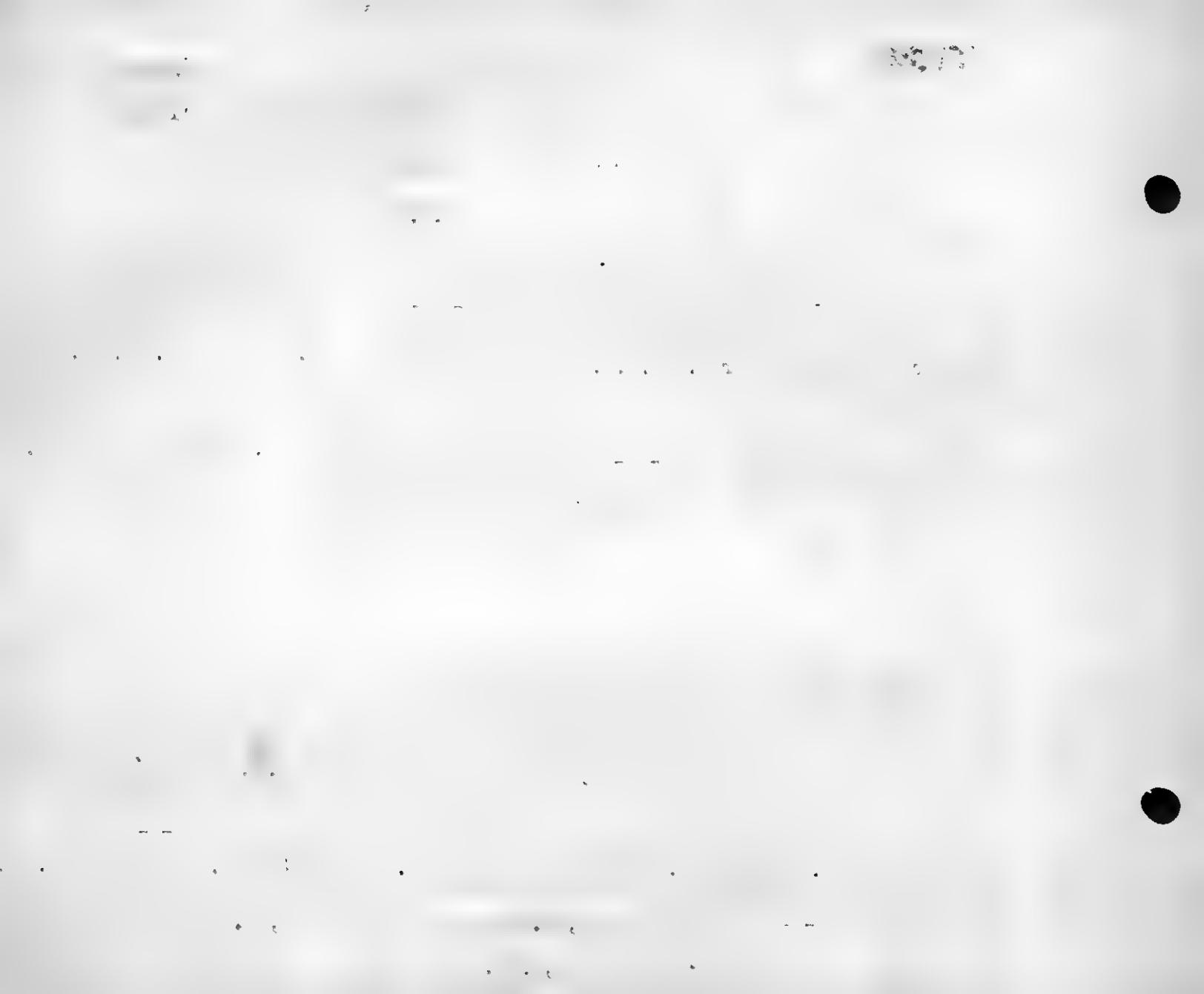
CERTIFICATE OF DEATH

00061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased resided if institution, Res. date & b. admission) b. STATE MARYLAND AT COUNT ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND LENGTH OF STAY IN lb 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYLINGS Rawlings	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS R.D.#3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First JOSEPH Middle F. Last SUMMERS		4. DATE OF DEATH Month JANUARY Doy 4 Year 67	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1896
9. AGE (In years lost 70 day yrs.)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman Helper B. & O.R.R.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) SCRANTON, PA.		12. CITIZEN OF WHAT U. S. A.	
13. FATHER'S NAME THOMAS SUMMERS		14. MOTHER'S MAIDEN NAME ANN Burke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 220-10-1896	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434/1 DUE TO Congestive heart failure & Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO pulmonary emphysema- stating the underlying cause (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22/67, 1967, to 1967, that (I) (we) last saw the deceased alive on 1/4/67, 1967, and that death occurred at M, from causes and on the date stated above		22b. DATE SIGNED 1-9-67	
22a. SIGNATURE Walter N. Himmler		22b. ATTENDING M.D. PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. WALTER N. HIMMLER		22d. ADDRESS 412 N. MECHANIC ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-7-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dawson, K.M.Cemetery		23d. LOCATION (City or Town) (County) (State) Dawson, Md. Allegany	
24. FUNERAL DIRECTOR Thomas Smith Jr. Keyser, W. Va.		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when please remove carbon papers pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

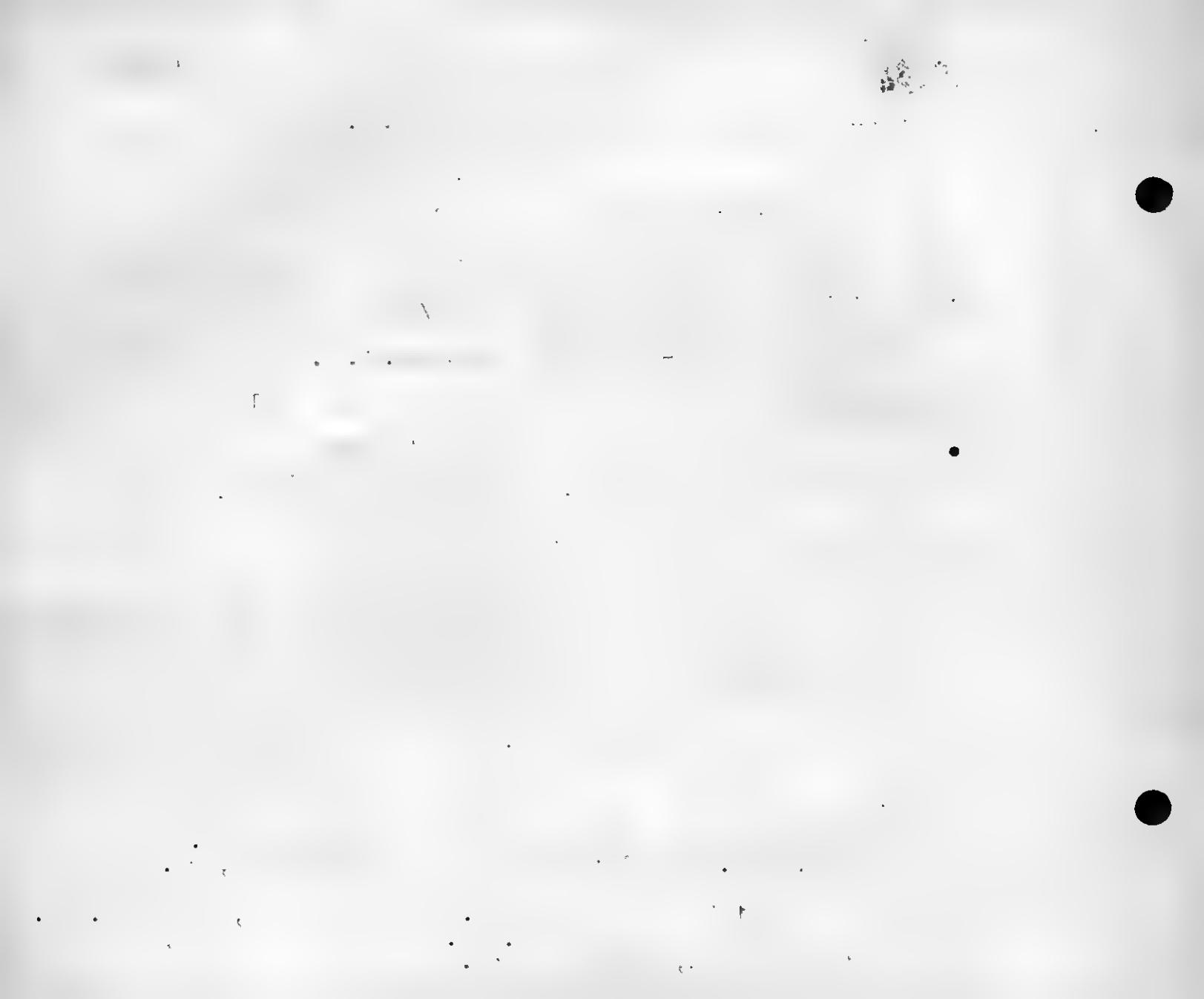
1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Md. W. Va. b. COUNTY Mineral ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCooie 3 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piedmont	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Thorne Nursing Home		d. STREET ADDRESS 234 W. Fairview	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED First John Middle Daniel Thomson		4 DATE OF DEATH Jan. 27, 1967	
S. SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1885 9. AGE (In years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (County & State, or foreign country) Garrett-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Thomson		14. MOTHER'S MAIDEN NAME Sarah Atwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 181-10-8063 17. INFORMANT Address Thomson G. Foreback, Beryl, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X <i>Coldness of skin</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVA. BETWEEN ONSET AND DEATH 0 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1967, 19, to 1-27, 1967, that (I) (we) last saw the deceased alive on 1967, 1967, and that death occurred at 1 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Boss, Jr.</i>		22b. DATE SIGNED 1-28-67	
22c. PHYSICIAN'S NAME (Type) Robert W. Boss, Jr.		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/67	23c. NAME OF CEMETERY OR CREMATORIAL Philos
23d. LOCATION (City or Town) (County) (State) Westernport Md.			
24. FUNERAL DIRECTOR <i>J. W. J. W.</i>		ADDRESS Westernport, Md.	
25a. REC'D BY REGISTRAR JAN 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		00063											
1. PLACE OF DEATH a. COUNTY Allegany				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE W. Va.				b. COUNTY Mineral									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Paw Paw				d. STREET ADDRESS c/o Postmaster									
3. NAME OF DECEASED (Type or print) Guy				First 1	Middle 	Last VanHorn		4. DATE OF DEATH 1 15 1967				Month 1	Day 15	Year 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/15/93		9. AGE (in years last birthday) 73 yrs.		10. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Paw Paw, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY --				11. BIRTHPLACE (County & State, or foreign country) Paw Paw, W. Va.				12. CITIZEN OF WHAT COUNTRY? USA													
13. FATHER'S NAME Clarence VanHorn				14. MOTHER'S MAIDEN NAME Myrtle Wolford				15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 				17. INFORMANT Patient's Chart									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. Common Ling.												INTERVAL BETWEEN ONSET AND DEATH Smoke 1 year													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work								20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED at work <input type="checkbox"/> Not White <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 to July 15, 1967 , that (I) (we) last saw the deceased alive on July 1, 1967 , and that death occurred at M , from the causes and on the date stated above.				22a. SIGNATURE Blane M. Shindler				22b. DATE SIGNED 4/17/67				22c. PHYSICIAN'S NAME (Type) Blane M. Shindler				22d. ADDRESS 43 Greene St.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/1967		23c. NAME OF CEMETERY OR CREMATORIUM Camp Hill Cem.		23d. LOCATION (City, town or county) (State) Paw Paw	
24. FUNERAL DIRECTOR Old Johnson				ADDRESS Johnson Funeral Homes, Berkeley Spgs.				25a. REC'D BY REGISTRAR W. Va.				25b. REGISTRAR'S SIGNATURE Charles Judge				DATE JAN 20 1967									
VR A15 (4) 20M 1/65																									



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

00064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 5, BOX 319-C, CUMBERLAND, MD.	
3. NAME OF DECEASED (Type or print) HARLEY		First VAN SICKLE	Middle L
4. DATE OF DEATH JAN 12 1967	Month JAN	Day 12	Year 1967
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1909
9. AGE (In years lost birthday) 57 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Auto. Industry	11. BIRTHPLACE (Country & State, or foreign country) Farnington, PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
14. FATHER'S NAME ENNIS VAN SICKLE	15. MOTHER'S MAIDEN NAME ELIZABETH FAULKNER	16. SOCIAL SECURITY NO 163-22-6771	
17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Heart disease</i> DUE TO (c) <i>Chronic Myocarditis and degeneration</i>			
INTERVAL BETWEEN ONSET AND DEATH Month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farnington
20f. (City or town) 19		(County) PA.	
(State) MD.			
21. I certify that (I) (this hospital) attended the deceased from Jan 9 1967 to Jan 12 1967 , that (I) (we) last saw the deceased alive on 1/12/67 , and that death occurred at 9:15 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>G. Overton Himmelwright</i>		22b. DATE SIGNED 1/13/67	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VA. AVENUE, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rural	23b. DATE THEREOF 1/15/67	23c. NAME OF CEMETERY OR CREMATORIAL Van Sickles Cemetery	23d. LOCATION (City or Town) Farnington, Fayette, Penna.
24. FUNERAL DIRECTOR H. Wayne George	ADDRESS Cumberland, Md.	25a. REC'D. BY REGISTRAR DATE JAN 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY ALLEGANY			2 USUAL RESIDENCE (Where deceased lived, if institution _____ Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 45 HENDERSON AVE.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) MABEL		First V.	Middle WADE	4 DATE OF DEATH JANUARY 13	Month Year 19 67
S. SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1892	9. AGE (In years lost birthday) 74 yrs	10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME GEORGE WILLIAM VAN HORN			14. MOTHER'S MAIDEN NAME DOROTHEA E. MC CREAMY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 331X IMMEDIATE CAUSE (a) CVA DUE TO Gingivitis arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis year (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CUMBERLAND (County) ALLEGANY (State) MARYLAND					
21. I certify that (I) (this hospital) attended the deceased from 1-6 , 19 67 , to 1-17 , 19 67 , that (I) (we) last saw the deceased alive on January 13, 1967 , and that death occurred at CUMBERLAND , Md., from causes and on the date stated above.					
22a. SIGNATURE B. M. Schindler		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/14/67	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22d. ADDRESS 43 GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR ADDRESS Philip B. Wendt 121 Mem. Ave., Cumb., Md.		25a. REC'D BY REGISTRAR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00066

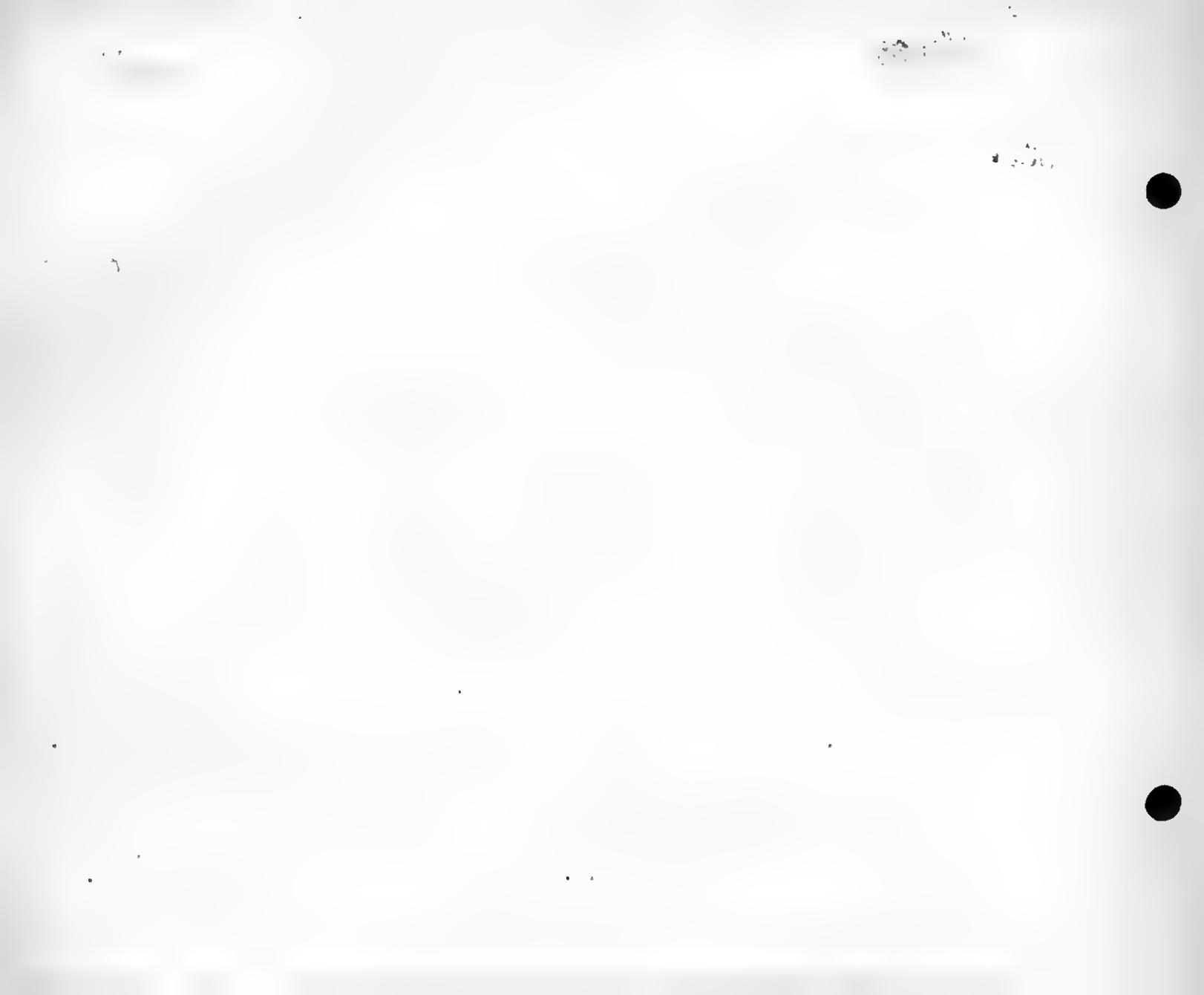
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00066

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if in institution, Residence before admission) a STATE MD. b COUNTY ALLEGANY V	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED First DEENA Middle REENA Last WERNER		4 DATE OF DEATH Month 1 Day 26 Year 1967	
5 SEX F	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b WIDOWED <input type="checkbox"/> D DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/6/66
10a US AL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? AMERICA	
13 FATHER'S NAME RONALD J. WERNER		14. MOTHER'S MAIDEN NAME SALLY PAPE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service		16 SOCIAL SECURITY NO	
17 INFORMANT RONALD J. WERNER, 50 OAK ST., FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Minutes	
(b) Strangulation in Crib DUE TO		"	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Crib side-rail fell impinging baby's head	
20c TIME OF INJURY Month, Day, Year Hour o.m. 6:30 Jan. 26 1967		20d INJURY OCCURRED 3 While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home
20f (City or town) Frostburg, Allegany, Md.		(County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE BENEDICT SKITARELIC MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 1-28-67	
23c NAME OF CEMETERY OR CREMATORIAL FINZEL CEMETERY		23d LOCATION (City or Town) (County) (State) FINZEL, GARRETT, MD.	
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.	
25a REC'D BY REG STRR JAN 30 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00067

CERTIFICATE OF DEATH

00067

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

3 Weeks

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

3. NAME OF
DECEASED
(Type or print)

First
Maudie

Middle
H.

Last
Wigfield

4. DATE
OF
DEATH
1 15 19 67

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

1/19/01

9. AGE (in years
last birthday)

65 yrs.

10. IF UNDER 1 YEAR

Months **6** Days **0**

11. IF UNDER 24 HRS

Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housekeeper

10b. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (County & State, or foreign country)

Springfield, West Va.

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

John E. Kaylor

14. MOTHER'S MAIDEN NAME

Nannie V. Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

patient's chart

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

17/11

DUE TO

Varicinomatosis

INTERVAL BETWEEN
ONSET AND DEATH

3 min

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

Carcinoma of Stomach

Oct. 1965

(c)

Cardiac Decomposition

June 6

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES ND

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. **19** Not White
p.m. **19** at work at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **1/19/67**, 1966, to **Jan 15, 1967**, that (I) (we) last
saw the deceased alive on **Jan 14, 1967**, and that death occurred at **M.** from the causes and on the date stated above.

22a. SIGNATURE

Clay E. Durrett

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
22d. ADDRESS

1/16/67

22c. PHYSICIAN'S
NAME (Type)

Clay E. Durrett M.D.

236 Virginia Avenue Cumberland, Maryland

23a. BURIAL, CREMATION,
REMDVAL (Specify)

Burial

23b. DATE THEREOF

1/18/67

23c. NAME OF CEMETERY OR CREMATORI

Wesley Chapel Cemetery

23d. LOCATION (City, town or county) (State)

Wesley Chapel

W. Va

24. FUNERAL DIRECTOR

H. Lee Silcox

ADDRESS

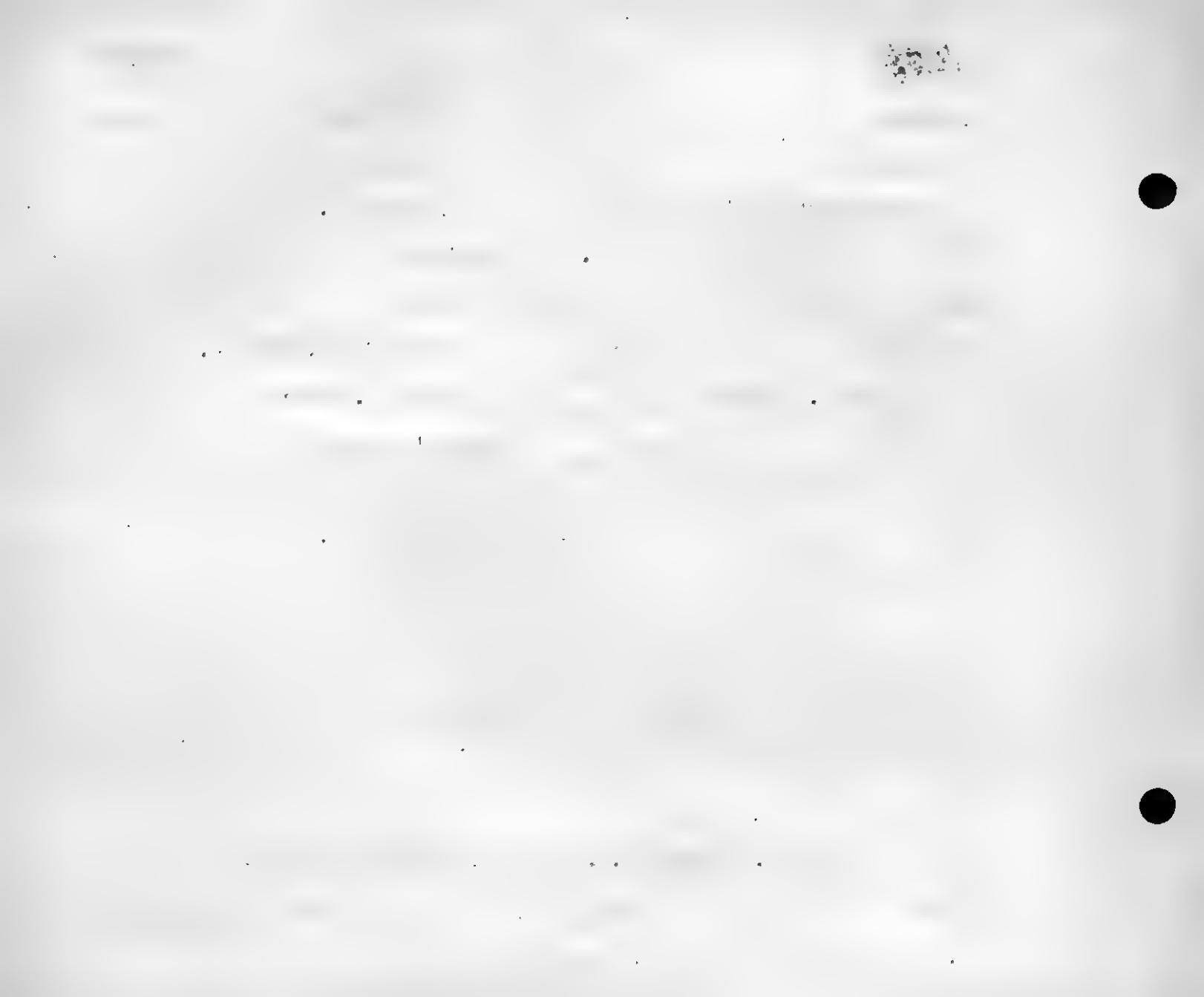
Cumberland Maryland 21502

25a. REC'D BY REGISTRAR

JAN 18 1957

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00068

CERTIFICATE OF DEATH

00068

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN lb 3 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	d. STREET ADDRESS RT. #1,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CARL	Middle E.	Last WILHELM			
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1903			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES				
11. BIRTHPLACE (County & State, or foreign country) BARRELVILLE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME EDWARD WILHELM		14. MOTHER'S MAIDEN NAME SARA DIEHL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 208-09-1868				
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO <i>Cancer of lung</i> INTERVAL BETWEEN ONSET AND DEATH 1 year						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 11 1966, saw the deceased alive on 1/4 1966, and that death occurred at 10:40 P.M. from causes and on the date stated above.				22b. DATE SIGNED 1/6/66		
22o. SIGNATURE <i>Al Weisman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/6/66		
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 7 1967		23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE'S CEMETERY		23d. LOCATION (City or Town) MT. SAVAGE, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS		25a. REC'D BY REGISTRAR JAN 9 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

23000

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00069

CERTIFICATE OF DEATH

00069

1. PLACE OF DEATH

a. COUNTY

allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Vale Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

564 A Street La Vale Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

maryland

b. COUNTY

allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Vale Md.

011

d. STREET ADDRESS

564 A Street

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

13/8/77

9. AGE (In years last birthday)

89

yrs.

10. UNDER 1 YEAR

11. UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (County & State, or foreign country)

Pittsburgh Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Joseph Bragg

14. MOTHER'S MAIDEN NAME

Margaret Kraut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.

No —

17. INFORMANT

Mrs. Rose Hardman La Vale Md. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

H28.1

myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

ARTEROSCLEROTIC

heart disease

10 hrs

DUE TO

(c)

HYPERTENSION

hypertension

20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

p.m.

19

While at work

Not While at work

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 12-22 1966, and that death occurred at S M, from the causes and on the date stated above.

22a. SIGNATURE

Louis Michael Glick M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. DATE SIGNED 1-3-67

22c. PHYSICIAN'S NAME (Type)

L. Michael Glick

22d. ADDRESS

126 N. Smallwood St. Cumberland,

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Louis Stein Inc. Cumb. Md.

DATE JAN 6 1967

j Charles Judge

03000

03000

03000 03000